HEALTH CARE, ECONOMIC OPPORTUNITIES AND SOCIAL SERVICES FOR VETERANS AND THEIR DEPENDENTS——A COMMUNITY PERSPECTIVE

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS
OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

MAY 5, 1993

Printed for the use of the Committee on Veterans' Affairs

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May 5, 1993

MATERIAL SUBMITTED FOR THE RECORD

HEALTH CARE, ECONOMIC OPPORTUNITIES AND SOCIAL SERVICES FOR VETERANS AND THEIR DEPENDENTS——A COMMUNITY PERSPECTIVE

WEDNESDAY, MAY 5, 1993

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 8:30 a.m., in room 340, Cannon House Office Building, Hon. Lane Evans (chairman of the subcommittee) presiding.

Present: Representatives Evans, Gutierrez, Kreidler, Ridge, Everett, and Quinn.

OPENING STATEMENT OF CHAIRMAN EVANS

Mr. EVANS. Good morning. We are investigating issues of concern to Vietnam veterans today, important issues that include veterans' health care, business and economic opportunities for veterans, and social services for veterans and their dependents.

Today's hearing is being held to coincide with the conclusion of the 12th Annual Conference on the Concerns of Veterans. When that conference was first organized more than a decade ago, it focused on issues primarily important to Vietnam and Vietnam-era veterans.

Over the years the conference has both grown and evolved. While many era veterans continue to participate, other veterans have also become more active in the conference.

Our witnesses today come from many different parts of the country. They represent many different backgrounds, and they pursue different vocations. They represent the diversity and strength of our veterans' community in our Nation.

While different in many respects, I believe that they also share several important similarities. First and foremost, they share a common interest in our Nation's veterans. They also share a community perspective on veterans' benefits and services.

The men and women who will be testifying here today do not live and work in Washington, DC. They are not among those who are routinely called upon to testify before congressional committees. Our witnesses today will, instead, provide this committee with a different perspective, a community perspective, on veterans' issues.

While several witnesses are affiliated with the Department of Veterans Affairs, they are here to present their personal and professional opinions, not the official views of the Department of Veterans' Affairs.

The subcommittee is pleased so many witnesses are here today to present their opinions. We look forward to their comments and extend a warm welcome to each of you.

I would like to inform everyone that the written statement submitted by each witness will be included in its entirety in the printed hearing record, without objection. Each witness is requested to summarize their comments as needed and to limit their presentation to five minutes.

Speaking at least for myself, I'll try to limit my questions so we can move right along and give everyone an opportunity to make their presentation before they are scheduled to leave town.

I would be glad to yield to any of my colleagues for any opening remarks that they would like to make at this time.

Mr. EVERETT. Thank you, Mr. Chairman.

We certainly appreciate you being here today. We know you're being true American patriots and look forward to hearing your testimony.

Mr. EVANS. Mr. Quinn.

OPENING STATEMENT OF HON. JACK QUINN

Mr. QUINN. Thank you, Mr. Chairman. I'm pleased to be a member of the committee. And thank you, Mr. Chairman, for putting together the hearing. I'm particularly pleased to see such strong representation this morning from New York State, my state, and from western New York, up around near Buffalo and Rochester.

I'd like to mention that I, Mr. Chairman, am going to be in and out of here today because of some other meetings that all of us have scheduled today. I'll try to get back for the testimony of those members from the western New York area.

I want to mention for the record that Mr. Bill Lyons is here. He's familiar to everyone involved in the National Conference on Concerns of Veterans and was recently named the Veteran Advocate of the Year by the SBA in Region Two back in Buffalo. We appreciate his invaluable insights to all of these topics.

Mr. Frank Falkowski and Mr. Jose Fuentes are the Chief Operating Officer and Program Director, respectively, for the Western New York Veterans Housing Coalition. I appreciate them being here and all the testimony we'll hear today.

Thank you, Mr. Chairman.

Mr. EVANS. We appreciate both your attendance here as well as the members that will join us.

I would like to acknowledge Dr. Paul Camacho and ask him to stand.

(Applause.)

Mr. EVANS. Paul is the Associate Director of the William Joyner Center, part of the University of Massachusetts, Boston Harbor Campus, but I think his impact on veterans' affairs reaches across our country.

Paul, more than any other individual, is responsible for the Conference on the Concerns of Veterans which is conducted annually in Washington and for the continuing success of this conference. He has helped us in many ways and we appreciate his outstanding contributions. Paul, we want to thank you for all of your valuable assistance and all of your efforts on behalf of our country's veterans.

It's a great pleasure and honor for me to now yield time to our distinguished ranking member of the committee, a combat veteran of Vietnam, Congressman Tom Ridge.

OPENING STATEMENT OF HON. THOMAS J. RIDGE

Mr. RIDGE. Thank you very much, Mr. Chairman. Given this is our first meeting of the year, I welcome you back in good health and welcome you back with an eye toward a very aggressive and very impressive agenda that you've got scheduled for the subcommittee. I think this year's agenda covers some subjects that are not only personal concerns of mine, but concerns of the entire veterans' community.

There is nothing of which I am more proud than my association with the three million men and women who served in Vietnam. It wasn't a conflict. It was a war. And nothing in my life, no association I've had with anybody in any phase of my life, has meant more to me than being able to be associated with those men and women.

And while I think back and see a lot of my friends in Pennsylvania who served and came back and have been assimilated back in their communities and are raising families and making contributions, there are still far too many Vietnam veterans who bear the scars of war. Some of them are physical. Some of them are emotional. And some, unfortunately, sustained both.

For whatever reason—and there are a lot of explanations—there's a substantial number of people who have not been assimilated back, haven't really had the kind of opportunity and the chances that I've had and a lot of Vietnam veterans have had since they returned.

So your continuation of this kind of hearing with this focus is very much appreciated. I must say to those assembled here that you and I have talked in the past about some of the personal concerns that I've had with regard to PTSD, Agent Orange, the filing, the timely filing, and response to claims.

And I think your record is pretty clear, Mr. Chairman. Since I've known you and since we've worked together here in Washington, you've been a very outspoken advocate on behalf of Vietnam veterans, Vietnam-era veterans, and veterans generally. So I'm really looking forward to working with you on a mutual agenda to promote and advocate the interests of veterans.

But this is a personal note. I'm very appreciative that you continue to hold this particular hearing with the emphasis on the problems that continue to plague Vietnam veterans and Vietnam-era veterans.

I would ask unanimous consent that my remarks be submitted for the record.

[The prepared statement of Congressman Ridge appears on p. 55.]

Mr. EVANS. Without objection.

Mr. RIDGE. Thank you.

Mr. EVANS. I appreciate your remarks and your continuing help on dealing with these issues.

I'd also like to note because of a very large and patriotic Hispanic population in my district that today is the 5th of May, or Cinco De Mayo. On May 5th in 1862, 6,000 French soldiers attacked Mexico in a war of conquest. Against overwhelming odds, 2,000 Mexican soldiers defending their homeland defeated the French invaders. This is, of course, a great national holiday in Mexican society and in their country as well as a great day in Mexican history and for people in my district, it's quite a holiday as well.

The members of our first witness panel are Dr. Suzanne Klimberg, Linda Schwartz, Jeff Tepsitch, and Aldo Rodriguez. If they could come forward and be seated, we would appreciate it.

Dr. Klimberg is the Chief of Women's Oncology at the John McClellan Memorial Veterans Medical Center in Little Rock. She is a distinguished member of the faculty of the University of Arkansas for Medical Sciences.

Linda is an Air Force veteran, and it's a pleasure to welcome her again before this subcommittee. She's an outstanding advocate for Vietnam-era veterans, and particularly women veterans.

Jeff is HIV/AIDS Program Coordinator at the VA Medical Center in Boston.

Aldo is an Army veteran and is testifying on behalf of the New England Gay, Lesbian, and Bisexual Veterans of Boston.

Doctor, we will start with you and work our way across the table. If you can pull the microphone closer to you, we would appreciate it.

STATEMENTS OF V. SUZANNE KLIMBERG, M.D., CHIEF OF BREAST SERVICE, SURGICAL ONCOLOGY, UNIVERSITY OF ARKANSAS FOR MEDICAL SERVICES, ARKANSAS CANCER RESEARCH CENTER, CHIEF OF WOMEN'S ONCOLOGY, JOHN L. MCCLELLAN MEMORIAL VETERANS MEDICAL CENTER; LINDA S. SCHWARTZ, RN, MSN, CHAIR, VIETNAM VETERANS OF AMERICA, INC., WOMEN'S VETERANS AND LEGAL AFFAIRS COMMITTEES; ALDO O. RODRIGUEZ, NEW ENGLAND GAY, LESBIAN, AND BISEXUAL VETERANS OF BOSTON; AND JEFF TEPSITCH, MSW, HIV/AIDS PROGRAM COORDINATOR, DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER, BOSTON, MA

STATEMENT OF DR. SUZANNE KLIMBERG

Dr. KLIMBERG. Thank you, Congressman Evans. It's a privilege for me to be here.

As the number of female veterans increases to nearly 10 percent of our veteran population, the specific programs that address their unique health care needs become a priority.

Most women veterans now receive no treatment or receive care in private hospitals. At a time when we're talking about whether health care is a privilege or a right, it's mandated that it is a right for our veteran population.

The current accessibility to medical care for women at the VAs is not unlike that for men. The problem lies in the lack of empathy for issues specific to women veterans. I have turned in some exhibits today that are directives that clearly outline services that are not provided for our women veterans.

Women clinics in VAs throughout the country do not meet the criteria for these mandates because they do not meet issues specifically for privacy and special needs, and they're still at issue.

Most are unable to comply with these needs because they do not have mammographic capability and they do not have funding to get such capabilities. To my knowledge, in the VA, there are only 23 VAs in the United States that have mammographic capabilities.

Screening of male and female veteran populations is mandated for primary, secondary, and comprehensive cancer centers, but it is not fully implemented. Unquestionably, screening will decrease the long-term cancer care costs in the VA.

The VA has taken significant steps on all levels: local, regional, and central. But these initiatives are far below what is needed in terms of cost care.

For example, in our women's program in the VA, less than .05 percent of the VA budget went for specific women's care and less than .01 percent went into women's research. At a time when the DOD has $20 million to spend on breast cancer research alone and has not spent it, less than half of that total went into any kind of women's funding.

In addition, residency programs that rely upon the hospitals for their major training as an added dimension for the VA research. VA research was a part of my major training. One of the prime directive of the VA is the VA residency training.

To that point, we lack facilities for women. So our training for our residency programs is less than adequate. This initiative for women will broaden the experience for our training and keep the quality of care in this country at its peak level.

Another prime directive for the VA mission is research. In 1980 two percent of the budget went to VA research. It is one percent of the VA budget now, of the research budget. It's less than .001 percent of the total budget. Not only does research permit recruitment of high-caliber physicians, but it also creates an intellectual environment.

If it were not for research, many high-quality physicians would not come to the VA. It's the carrot on the end of the stick that we get physicians into the VA. If it were not for that, we will lose them.

The VA research is different than any other research. VA research is clinical research. Greater than 80 percent of VA research is clinical. That's in contrast, opposite, to what the NIH is, which is mostly basic science research. And though we get three percent of what the NIH gets for research, we fund more than one-third of clinical research in this country.

It's clear from the present budget figures that the VA will not be allowed to make any new initiatives in the fiscal year 1994. And, in fact, we won't be able to keep up the current level. We will lose about 700 jobs.

It should be made clear that cutting VA research will not save money for the VA, but it will increase long-term health care costs. An easy number to remember, it will double the health care costs.

For example, there was a cost-effective study done in Milwaukee, where just in one hospital, it would cost $4 million more just to contract out care, health care, because we get health care from our physicians at a much lower cost if we can wave research dollars in front of them.

It should be also made clear that available studies, for example, in the area of breast research, are going unfunded and lack sufficient numbers of patients. The VA is unique in that we have a network throughout the country where we can do large clinical prospective trials to answer questions in breast research.

And in the VA population, we believe and small studies do show breast cancer and cervical cancer are increased in our veteran population, but no significant study with a significant amount of numbers has shown this in our population. And if this is true, we should be looking into this and funding women's research more.

I want to summarize that not only programs are needed to address unique health care needs to women, but also support for this care and research in women veterans must be provided. These efforts are important to maintain in advanced health care, research, and medical training in this country.

We are speaking today of women's veterans' issues, but I assure you that by supporting these issues, you are not only supporting women's veterans, you are directly improving the level of care to all veterans.

This should not be a policy of exclusion, but inclusion. Veterans should be second class no more. Put the veteran first. Thank you.

[The prepared statement of Dr. Klimberg, with attachments, appears on p. 56.]

Mr. EVANS. Thank you, Doctor.

Go ahead, Linda.

STATEMENT OF LINDA S. SCHWARTZ, RN, MSN

Ms. SCHWARTZ. Good morning, Mr. Chairman. I want to thank you again for inviting me to this hearing, and I want to thank you for your continued interest in veterans, and especially with women veterans' health care.

This morning I want to talk mostly about the present climate in health care with the idea of the Task Force on Health Care Reform. We know that most veterans, including Vietnam veterans, see the VA as the most tangible evidence of any concern on the part of the government for our service and the things that we've done.

For many veterans, I'd say without question the greatest issue of concern right now is: What is this health care reform going to be doing to the VA system? What will veterans be able to look for in the future as care designed specifically for them? While some people feel this is a time of crisis, I feel that it's a time of opportunity.

What we have neglected to do in the past, is to look at all of the resources that are devoted on the state, local, and even on the city

level to veterans. We need to get a handle on that and see how they dovetail and how they can make things work.

We need to consolidate the available resources to assure that veterans who are eligible and in need definitely have the care that they deserve. Along with this will be the opening of many doors.

The doctor just talked about research, but we have to put it in the light of a new generation, a new kind of health care for this country, one where opportunities for research will not just be in the VA, one where opportunities for collaboration and reciprocal agreements will be a way in which we can make the maximum utilization of any of the resources that we presently have.

This last February I addressed the committee, the National Academy of Science Committee, that's looking at the effects of herbicides on Vietnam veterans. I was there to talk to them about women veterans. One of the things that just really floored me at that particular time was that this committee has been meeting for almost two years, and they were laboring under the notion, because someone had said, women who served in Vietnam were not exposed to Agent Orange. They were laboring all this time under that notion.

I can tell you that I hope I enlightened them a little more because it's very, very important. However, it brings up a case the doctor was just referring to. You don't really have any hard current data on the health concerns and problems of women veterans.

For my doctoral dissertation I am doing an additional analysis of the National Vietnam Veterans Readjustment Study. Initially we have found something that's very, very interesting. Out of the population of about 432 women, six of them have multiple sclerosis, which is very striking. Six of them have tuberculosis.

When you think of six cases in 432 women who served in Vietnam, that at the same time the national average was 6 in 100,000 of the population of America. You can see that some of these health care concerns are things that we should be looking at and planning and providing for.

Another thing that we have found is that women who served in Vietnam do, indeed, have a greater percentage of negative reproductive outcomes, children who die before the first year, miscarriages and stillborns.

So this is what we're doing. We're just trying to take what we have, what we have right now, and maximize what we can learn from it. The most important thing, and I would like to suggest to you, is that NIH talks about how we must have women in all studies.

I would submit to you that a way we could take a look at this quickly is to have NIH include in all of their studies of women questions of military service. That might help to enlighten us. That's a cost-saving procedure and approach to finding out without going overboard. It takes just a little paper shuffle, so to speak, to do that.

The last thing I want to talk about is the National Vietnam Veterans Readjustment Study. What the NVVRS did—in reference to social services for families—was to ask questions about spouses and the families of veterans who have Post-Traumatic Stress Disorder. In addition to that, there were questions about high war stressors.

One of the findings was that these families really are in need. I can tell you this from my own experience working with groups of women who are spouses.

When you have a child who comes home from kindergarten at five years old and has trashed the kindergarten room, just as the father trashes the house when he gets angry, mothers are hard put to know what to do. When children are too slow to learn because of the violence in the house, we have to look beyond treatment approaches of the past and see if there is not a way in which to help these families.

I know that there are several people within the VA who have been looking at this problem and do have a lot of knowledge about this, but we have to develop it so that we can really help.

You can't just treat a veteran with Post-Traumatic Stress Disorder or any disability, whether it be psychological or physical, in a vacuum. It's a family problem. And it takes a lot of concern and care and work on the part of the family to actually support the veteran in these needs.

So what I'm trying to say is the kind of health care that our President envisions for this country does not mean that veterans have to be lost or that the VA health care will suffer. What it means is that we have to look for the opportunities to work with each other, with the state governments, and with other citizens and veterans' service organizations to bring together all of these in a network so veterans and their families receive the care they need. Thank you.

[The prepared statement of Ms. Schwartz appears on p. 68.]

Mr. EVANS. Thank you.

Mr. RODRIGUEZ.

STATEMENT OF ALDO RODRIGUEZ

Mr. RODRIGUEZ. Good morning, Chairman Evans and committee members. I am here today to testify on behalf of minority Vietnam-era veterans and their concerns. These minority veterans are black, Hispanic, Asian, American Indian, homeless, gay, lesbian, and bisexual.

I am a gay minority Hispanic veteran and active member of the New England Gay, Lesbian and Bisexual Veterans of Boston. I served in the U.S. Army in 1977 and was honorably discharged. Today I work for the Department of Veterans Affairs Outpatient Clinic in Boston as a medical/eligibility clerk. On a daily basis I am confronted with minority veterans and their concerns.

Studies indicate that about one-third or more of the adult homeless population in the United States served in the armed forces. An estimated 150,000 to 250,000 veterans are homeless. A disproportionate amount of the homeless veterans coming for treatment at the VA Outpatient Clinic in Boston are black. These black veterans nine times out of ten are homeless as a result of physical or mental wounds, like PTSD, Post-Traumatic Stress Disorder, caused in combat service in Vietnam.

Lack of treatment for this condition as a result of lack of knowledge of VA care available to treat such condition is the result of the veterans' homelessness. I find that many of the veterans are

not even aware of their benefits and the many treatment clinics available to them.

With respect to Hispanic veterans, I find that their biggest concern is the existing language barrier. Often Hispanic veterans coming for care at my facility speak very little English, if any at all. At the clinic, there are very few, if any, professional bilingual medical staff.

When the U.S. military drafted these veterans for war, it couldn't care less that these Hispanic veterans knew little, if any, English at all. And today it isn't that easy for an older person to learn a new language, especially a person with physical and mental problems caused by combat service. Many Asian veterans seeking treatment at the clinic are confronted with the same problem of language.

Even though drug and alcohol use and abuse are rampant in the black, Hispanic, and American Indian communities, almost 99 percent of the veterans enrolled in the VA Clinic's Methadone Unit are white male Vietnam-era veterans. I believe it is a direct result of lack of community outreach to minority veterans.

Because of the 50-year ban officially excluding gay men, lesbians, and bisexuals from military service, gays are the most apprehensive when seeking care or counseling at VA medical care facilities or federal vet centers.

There are gay veterans that are infected with AIDS. Because of the double stigma of both being gay and infected with AIDS, many gay, lesbian, and bisexual veterans avoid medical care out of fear that they may end up receiving judgment, rather than medical treatment. Many gay veterans confronted with AIDS fear that most counselors and other medical staff will not be sensitive to their special needs and concerns.

In order to address the needs and concerns of the minority veterans I have mentioned, the following are my recommendations to the committee. One, with the cooperation and assistance of community leaders, develop community outreach programs for minority veterans to educate and inform minority veterans of the many medical benefits and treatment facilities available upon leaving active duty.

Two, the Department of Veterans Affairs hiring more bilingual professional staff doctors, nurses, clerks to work in its medical care facilities to help non-English-speaking veterans with translation.

Three, there are 195 federal outreach vet centers. Hire gay counselors at these facilities to address the unique concerns of gay, lesbian, and bisexual veterans.

And, finally, number four, support the Honorable President Bill Clinton in his efforts to lift the 50-year-old ban on gay, lesbian, and bisexuals serving in the U.S. military.

In conclusion, many minority veterans, black, Hispanic, Asian, American Indian, homeless, gay, lesbian, and bisexuals, have served with honor and distinction in Vietnam and other wars. Please recognize their needs and concerns.

And, if I may just add, with respect to gays in the military, in 1982 lawyers took a deposition from a two-star general who made an impassioned defense of the gay exclusion for the court record in a gay rights court case, but then over lunch unofficially admitted

he expected that the regulations would fall within a few years. He added, while he would deny saying this in court, that the change would be fine with him because he knew many fine gay soldiers. That general, Norman H. Schwarzkopf, led U.S. troops in the Persian Gulf.

Thank you.

[The prepared statement of Mr. Rodriguez appears on p. 77.]

Mr. EVANS. Thank you.

Mr. Tepsitch.

STATEMENT OF JEFF TEPSITCH, MSW

Mr. TEPSITCH. Mr. Chairman, members of the committee, thank you for inviting me to appear before the subcommittee today. I would like to take this opportunity to address two matters. First I will give a brief report on the HIV/AIDS Program at the Department of Veterans Affairs Hospital, Boston. Second, I would like to share with the committee current and projected treatment needs.

The AIDS epidemic continues to grow, claiming the lives of more people daily. As of March 1993, 171,890 people in the United States have died from AIDS. An estimated 1.5 million people in the U.S. are currently infected with the HIV virus. It is currently estimated that one out of every 100 men and one out of every 800 women in this country are infected with the HIV virus.

The Department of Veterans Affairs has treated over 14,000 cases of AIDS as of December 1992. In December 1990 the Department of Veterans Affairs had treated 10,129 cases of AIDS. As of December 31, 1992, the Department of Veterans Affairs had treated 14,649 AIDS cases. This amounts to a 45 percent increase in two years.

The HIV Program at the Department of Veterans Affairs,Boston provides a specialty clinic to help HIV-positive veterans cope both medically and psychologically with their disease. Our clinic is staffed by the Infectious Disease Chief, his staff of ID physicians and fellows, a clinical Salk vaccine nurse, a Ryan White grant-funded social worker, and myself.

Most veterans seeking care present at intake with a multitude of psychosocial problems. Many have active substance abuse problems, are homeless, lack an income, or are having difficulty coping with their HIV disease.

Many veterans find it difficult to seek care at a VA as they see themselves as unworthy, either because of their substance abuse history or the fact that they have previously denied their homosexuality. Many expect to be treated shabbily, but recognize the need for care.

It is crucial to help veterans feel welcome, provide supportive counseling, and help them obtain benefits to help stabilize their lives so that they are better able to cope with their HIV disease.

Social workers help veterans apply for entitled benefits and locate affordable housing. Currently there is a significant shortage of safe affordable housing in the Boston area. Based upon my experience, veterans are not very compliant with keeping their medical appointments for follow-up of their HIV disease when worried about where they are going to sleep that night or what they are

going to eat. Social workers help veterans access substance abuse treatment as well as provide individual or group therapy to help veterans cope better psychologically with their disease.

One area of particular concern to me as a social worker is disability benefits once a veteran becomes disabled from AIDS. Veterans may apply for Social Security disability benefits or a non-service-connected pension upon obtaining an AIDS diagnosis. In order to apply for a non-service-connected pension, the veteran must have served in the military for at least 90 days during a time of war.

I feel that the Social Security Administration and the Department of Veterans Affairs are doing an excellent job in determining when someone is truly disabled from AIDS and can no longer realistically be expected to maintain gainful employment, but it is a reality of how these decisions affect a person's ability to obtain medical insurance that concerns me.

For example, if a 40-year-old man who has worked the majority of his adult life is diagnosed with AIDS and can no longer work as a consequence of the disease applies for Social Security disability benefits, he will certainly be awarded a monthly income based upon the number of quarters he has worked as well as the salary he obtained when able to work. The Social Security Administration will then calculate the amount of his monthly check to which he is entitled.

This 40-year-old will not be entitled to Medicare until he has been receiving his Social Security check for two years. This sends a conflicting message. On the one hand, the message is that you are disabled, but, on the other, not entitled to insurance for a period of two years. Currently from the date of an AIDS diagnosis to death is approximately two to three years.

When Social Security and Medicare were first implemented, they were designed to provide a form of supplemental income and medical insurance to the elderly and disabled. Back then nobody envisioned AIDS and its consequences among so many of this Nation's young.

Veterans who served during a time of war and become disabled due to AIDS are entitled to apply for a non-service-connected pension. Once determined eligible, they are awarded a monthly check in excess of what SSI would pay.

Currently the monthly amount for a single veteran is $617 per month. In Massachusetts the maximum allowable monthly income for a single person to be eligible for Medicaid is $580 per month. Therefore, the awarding of a non-service-connected pension automatically makes one ineligible for Medicaid.

In the early stages of AIDS, the lack of insurance is of little consequence to veterans as they may obtain their medical care at Department of Veterans Affairs hospitals. As their disease progresses, veterans are faced with deciding where to die, whether in a VA hospital, an institution such as a residential AIDS hospice, or at home. Arranging for a veteran without insurance to be discharged to an AIDS hospice or die at home is extremely difficult without a payment source for needed services.

In closing, I wish to state that I honestly feel that the Department of Veterans Affairs is doing a great job caring for the needs

of HIV-infected veterans. It is the job of the VA to provide equal access to health care, regardless of lifestyles. I feel we are doing an admirable job providing medical, psychological, and substance abuse treatment, as well as helping veterans access benefits to which they are entitled.

I thank you for your attention and concern.

[The prepared statement of Mr. Tepsitch appears on p. 80.]

Mr. EVANS. I want to thank this panel very much. We will be holding a hearing on women veterans, I believe in July, not only dealing with the medical issues, but also dealing with the problems women have had being sexually assaulted in the military and the response of the VA to that. Obviously, the issues that you've raised give us extra information as we prepare for that hearing. We'll be addressing a lot of those individual questions.

Congressman Ridge and I have talked about differences in the level of care and equipment, mammography equipment and so forth, as you alluded to, Doctor, in your written statement. It's disturbing to me.

Perhaps because the resources devoted to HIV and AIDS vary in different parts of the country, you can get different kinds of treatment from the VA, depending upon where you live. That's something that I think is an ongoing concern in a variety of different areas that we need to address.

Obviously, language barriers and trying to get people to come into our facilities, particularly Vietnam-era veterans, who are quite often frustrated with the bureaucracy, hesitant to come into government facilities, are ongoing problems that we have always tried to address and will continue to address.

Let me ask if any of my colleagues have any questions.

Mr. RIDGE. I just have a couple, Mr. Chairman, if I might.

Dr. Klimberg, I just wanted to make sure of the statistics you gave us because they were stark and very revealing in terms of the percentage of VA research dollars specifically focused on women's health care issues, women's research. Am I correct? Was it one percent or one-tenth of one percent?

Dr. KLIMBERG. It's one percent of one percent. It's $2 million, $2 million fiscal year 1992. I went through Dennis Smith, who is head of research and development at the VA to get the exact number. Two million dollars in fiscal year 1992, went for women's research. It's one percent of one percent. They are startling numbers.

Mr. RIDGE. It is. I did a double-take when you said it, and that's why I wanted to come back and talk to you about it. There are a lot of projects, I could envision——

Dr. KLIMBERG. That's an increase.

Mr. RIDGE (continuing). Where you would need the entire $2 million, and that wouldn't be enough.

Dr. KLIMBERG. I put in a grant for $5 million to put in a women's program, very minimal, basically just what I needed, just everything, $5 million at one institution.

They have come out now for clinical, not research, but clinical. They have funded $7.5 million. That's all that went into clinical last year for specific unique women health care needs. Three million went to develop four centers at $750,000 apiece, at 15 percent of what's needed to develop those centers.

Ms. SCHWARTZ. I would like to say that last year was the first time in the history of the Congress that you ever voted to allocate funds specifically for the research.

One of the things that I have learned over the years is that you can make these allocations of funds, but there's no accountability. Time and time again we come to the Congress, and you hear the same things from women veterans.

There's nothing within the VA to have accountability. One of the things that I suggest in my testimony and I suggested before is that we need to look at creating within the Department of Veterans Affairs an office or a program of women veterans so that there's some accountability of "Where is this money going? What kind of research? What are the needs?"; instead of the "No. They have women veterans' coordinators."

Last year the Comprehensive Bill for Veterans' Health Care did contain provisions for women veterans' health, but there's no accountability and also for women veterans' coordinators, to be funded.

I think that its one thing to put money there, but whether it's used for what it's supposed to do is another thing.

Mr. RIDGE. Well, along the same line, though, could you familiarize this panel with the procedures presently employed with respect to research generally? Does the research approach, inclusive of female veterans—what I'm saying is—isn't there a small portion of funds set aside for female veterans' issues.

Ms. SCHWARTZ. In 1983 the then Administrator of the VA directed that all studies that were done by the VA, that were contracted out by the VA would include women. That, in fact, has not happened.

Mr. RIDGE. Okay.

Ms. SCHWARTZ. The National Vietnam Veterans Readjustment Study was the first time women veterans were included in any study of the Vietnam generation.

Mr. RIDGE. So in terms of when they're looking for the population to survey or tests to involve in the studies, there's not a proportional representation of female veterans reflecting the veterans' population at the time. Okay. Good.

Mr. Rodriguez, I'd like to ask you about the concerns you've expressed with regard to lack of education, lack of information within the minority veterans' community vis-a-vis some of the treatment opportunities that they have as well as the concerns about the absence of bilingual employees within the Department of Veterans Affairs.

That is a problem we have with a lot of government programs, whether it's the Federal or the state level. We can design a program, have people declared eligible, talk to them about access, but getting the knowledge and the information in their hands in terms of their eligibility is something that historically we have a problem with, be it veterans or anybody else.

Do you have any specific suggestions or thoughts based on your practical experience within the veterans' community? Where is the best place to disseminate or how do we get this information out to them so they know that these services are available?

I mean, it's across the board. Legislators can pass programs. We can appropriate money. But getting the information out so that people know they're eligible, that's always a problem for us.

Mr. RODRIGUEZ. With respect to my experience, I was hired as an eligibility clerk, but I spend most of the time running up and down the VA translating for Hispanic veterans when they come in for a compensation exam. That's what I end up doing, even though I wasn't hired as a translator.

I think that the best way would be with respect to reaching to the communities, like a community outreach program. That can only happen if you got a hold of a Hispanic veteran, let's say, that worked in the VA system and they turned around and went out to the Hispanic community and let them know that "These services are available to you."

Also another thing that can be done is while they're being processed out of the military, they can be informed that they have benefits because I'm shocked that there are veterans coming in from the Persian Gulf. These are young males and many of them white. And they have no idea that they're eligible for just more than the 90-day dental.

Some of them tell me, "Oh, besides the dental, am I eligible for any other benefits?" I said, "You served four years, plus you're Persian Gulf." He said, "When does it end, in six months?" I said, "No. You're eligible for all medical treatment." And they tell me, "They just told me it was dental within 90 days." I said, "No. Dental is within 90 days if you have less than two years in the military." But I tell them, "You've been there for four years. You're eligible for everything." "Is that so?" They have no idea.

Maybe something could be done also while they're being processed out of the military because I'm surprised that they don't even know, even today. I was shocked that the young people coming out have no idea. I thought it was just the older vets, but I'm finding that even the young vets don't know that they're eligible for anything.

And then a big problem we have is that it isn't standardized. So you have vets coming in and saying, "They gave me glasses in Florida." I tell them, "Are you service-connected for the eyes?" "No." "You can only get an eye exam." That's how it is in Boston.

And then they opened a new facility in West Roxbury. "Sorry. They're only taking service-connected vets."

Mr. RIDGE. Thank you. Thank you, Mr. Chairman.

Mr. EVANS. The gentleman from New York.

Mr. QUINN. Thank you, Mr. Chairman, just a comment and one brief question.

Dr. Klimberg, I have a local veterans' advisory committee that helps me in Buffalo on these kinds of matters. And the chair of that group is Dr. Joanne Zulewski, a woman vet who heads up the department of the Buffalo vets. If it's okay with you, somewhere along the line, I would like to put her in touch with you——

Dr. KLIMBERG. Yes.

Mr. QUINN. These issues are certainly important to all of us. That little committee helps me out back in western New York and Dr. Zulewski would be very well-informed to hear more from you. Is that all right?

Dr. KLIMBERG. Yes.

Mr. QUINN. Thanks very much.

Ms. Schwartz, I want to get back to the questioning that Mr. Ridge began in terms of research because I'm a former school teacher. Research and study and surveys are critically important, I think, in any area, especially when it relates to health care.

When you go in to sample, when you go in to research or study any group for anything, it needs to have the widest scope possible to make the study worth anything when you're finished.

Not to be repetitious: You're saying that if we do any work at NIH, it has not been including women veterans, even though they were directed since 1983 to do that?

Ms. SCHWARTZ. No. The research that I was referring to in 1983 was the VA, the Department of Veterans Affairs.

Mr. QUINN. Okay.

Ms. SCHWARTZ. What I was suggesting by my comment about NIH is the fact that they have said that they're going to include women in all of their studies. Rather, what I was suggesting is that NIH add questions about military service to their survey of women in America. That would be a way in which to garner some of that information. At present I don't think they do, and I think that this would be a very cost-effective way of looking at it.

Mr. QUINN. I agree.

Ms. SCHWARTZ. On the other hand, in 1986 Congress passed a law to study the effects of Vietnam on women who served in Vietnam. That study has not been done. It has been fragmented and pieced out, you know, a look at this, reproductive outcomes and things like that, here.

But what we really need to do is get a handle on what are the needs of our women veterans as a new generation of women comes out of military service so that you can base your planning for the future needs of the Department of Veterans Affairs on facts, real numbers, real things that are happening, rather than hoping that some of these needs get articulated at a level high enough to be responded to.

Mr. QUINN. I couldn't agree more. And I'm not familiar with all of it, Mr. Chairman. I'll learn more. My first 120 days are over up here on the Hill, but it seems to me that that's not a lot more than just some paper shuffling around to get that information. I mean, you said it. I agree.

Ms. SCHWARTZ. I have great hopes for this committee.

Mr. QUINN. Well, thank you.

Dr. KLIMBERG. Let me emphasize again that the VA research—you can't just say "Let's do the NIH" because although the VA gets three percent of what the NIH does, yes, they do more than one-third of the clinical work. If we're not emphasizing women, then who is?

The VA is very important research. The VA received two Nobel Prizes for CT scanner development, for the Seattle foot. There's so much clinical research that came out of the VA, and it can't be overemphasized. They base 75 to 80 percent of what they fund on clinicians. Nobody else does that.

Mr. QUINN. Sure. Thank you both very much. Mr. Chairman, thank you.

Mr. EVANS. Thank you.

The gentlemen from Washington State? No further questions? All right. I want to thank this panel for your time and efforts.

Mr. EVANS. The members of our next panel are Gary May, Joan Furey, Dr. Jonathan Shay, Warren Quinlan, and Michael Blecker.

We want to welcome Gary back before the subcommittee. Gary appeared before the subcommittee several years ago in Huntington, Indiana. He's a highly decorated combat veteran of Vietnam and serves as Assistant Professor of Social Work at the University of Southern Indiana. He's also a member of the Board of Advisors, Agent Orange Class Assistance Program.

Joan is a Vietnam veteran. She serves as Associate Director of Education with the National Center for Post-Traumatic Stress Disorder at Palo Alto, California VA Medical Center. Joan has also testified before the subcommittee, and it's a pleasure to welcome her here today.

Dr. Shay is a psychiatrist and specializes in the treatment of combat veterans with Post-Traumatic Stress Disorder. He's a part-time employee of the VA Outpatient Clinic in Boston, a member of the Tufts Medical School faculty and an author.

Warren is a Vietnam combat veteran. He is Director of Shelter Operations for the New England Shelter for Homeless Veterans, a 150-bed veteran-run shelter in Boston.

Michael is Executive Director of Swords to Plowshares in San Francisco, California. The Chair acknowledges and appreciates the significant contributions Mike has made ever since I've been in Congress and even before.

We will proceed with Gary, if he will begin. Please pull the microphone closer to you.

STATEMENTS OF GARY E. MAY, ASSISTANT PROFESSOR OF SOCIAL WORK, UNIVERSITY OF SOUTHERN INDIANA AND MEMBER, BOARD OF ADVISORS, AGENT ORANGE CLASS ASSISTANCE PROGRAM; JOAN A. FUREY, RN, MA, ASSOCIATE DIRECTOR OF EDUCATION, DEPARTMENT OF VETERANS AFFAIRS, NATIONAL CENTER FOR POST-TRAUMATIC STRESS DISORDER, CLINICAL LABORATORY AND EDUCATION DIVISION, VETERANS AFFAIRS MEDICAL CENTER, PALO ALTO, CALIFORNIA; MICHAEL BLECKER, EXECUTIVE DIRECTOR, SWORDS TO PLOWSHARES; JONATHAN SHAY, M.D., PH.D; AND WARREN QUINLAN, DIRECTOR OF OPERATIONS, NEW ENGLAND SHELTER FOR HOMELESS VETERANS

STATEMENT OF GARY MAY

Mr. MAY. Good morning. Chairman Evans and members of the committee, thank you very much for inviting me to testify today on the topic of "Heath Care, Economic Opportunities and Social Services—A Vietnam Era Veteran's Perspective."

My name is Gary May. I'm a combat-disabled Vietnam veteran and a certified clinical social worker currently on the faculty of the University of Southern Indiana. I serve as a member of the court-appointed Board of Advisors to the Agent Orange Class Assistance Program, commonly known as AOCAP.

I would like to speak to you this morning about the experiences which I and many others have had with the Vietnam veterans' community through that program. I will address some selected issues within the broad categories outlined in your hearing announcement, which I believe through my experience with AOCAP projects represents significant areas of unmet needs among Vietnam veterans and their families.

The range of these needs is wide and cannot be met without a reconfiguration of existing services and resources and a reordering of the priorities and philosophy underlying existing programs.

As most of you know, AOCAP was established to distribute a portion of the fund created by the settlement of the class action lawsuit by Vietnam veterans and their families against chemical companies which supplied herbicides used in Vietnam. AOCAP provides funding through grants to nonprofit organizations for services to Vietnam veterans and their families.

My complete written statement includes an overview of the history of the program and how its funding and service philosophy has evolved over the four years of its operation.

Currently AOCAP funds 76 projects, which are providing services in all 50 states plus DC and Puerto Rico. AOCAP has distributed over $34 million since its establishment in 1989, and it should distribute over $65 million, including interest, when its mission is completed in mid-1995.

Important lessons have been learned through the development and operation of AOCAP since 1989. The public policy implications are many. Unfortunately, the opportunities for sharing these implications are limited. Since AOCAP operates under the direction of a federal court, it is strictly prohibited from legislative advocacy in any form or manner. So the staff of the program cannot engage in lobbying for any broad mandate or any specific legislative or budget item.

Speaking as an individual and as a professional with many years of experience in human services, I feel a need to articulate some general policy recommendations extracted from my experience as an AOCAP advisory board member.

There is a strong feel among members of the board, the staff, and the directors of our projects that AOCAP has constructed a number of effective service models and strategies and that this is the appropriate time to begin to share those discoveries and innovations.

The most significant of these lessons and the ones with the most critical public policy implications are as follows: the importance of family-centered service strategies. Since the plaintiff class in the Agent Orange lawsuit includes families, a service orientation of AOCAP projects has always been family-based.

Project staff report a high degree of dysfunction among many Vietnam veteran families, which appears to be directly related to Post-Traumatic Stress Disorder. They also report that, especially for Vietnam veterans, counseling strategies are only minimally effective if they neglect the family, even when PTSD is the central treatment focus.

We must realize that Vietnam veterans are now an average age of 46 and have families. Family-centered service is the norm in

modern human service programs outside of the veterans' world, especially in the provision of counseling service to a population with the demographic and need characteristics of Vietnam veterans and their families.

Currently the VA's vet centers provide very little family counseling. The VA, especially in its counseling rehabilitation and vocational guidance programs, should be directed to consider the needs of veterans in the context of their families, both to ensure that the needs of the veterans are more appropriately addressed and so that veterans' programs can be integrated with other human services.

The importance of integrating services: Human services efforts are greatly enhanced by marshalling resources beyond program or agency boundaries through networking with other organizations.

AOCAP has funded agencies which are able to interface with other service providers. And in most cases AOCAP projects are now employing a true systems approach in dealing with Vietnam veterans and their families. The effectiveness of this systems approach has been unquestionable.

An action should be taken to assure that veterans' services at the Federal level are better coordinated, both within the VA and among the various agencies involved in such services. Efforts should also be made to develop service relationships with appropriate state, local, and community human service organizations.

The importance of case management or service coordination: The problems AOCAP projects encounter among Vietnam veterans and their families are usually complex and longstanding. The AOCAP experience is that for this population, it is only marginally effective to offer single-faceted service, such as counseling. Case management is also necessary.

The benefits of community-based organization service delivery: AOCAP contracts with many community-based veteran service and other service providers who have a fairly extensive network of communication, a very high degree of sophistication and skills, and a demonstrated effectiveness in providing services at the grass-roots level.

It is important, I think, for the committee to consider options which include contracting for certain services to these community-based organizations with a demonstrated effectiveness in delivering that service.

I would encourage you to consult and follow up with the staff of the Agent Orange Class Assistance Program on any of the points in my statement which might be unclear or would require additional elaboration or clarification.

Thank you again for the opportunity to present testimony before your committee.

[The prepared statement of Mr. May appears on p. 86.]

Mr. EVANS. Thank you.

Ms. Furey.

STATEMENT OF JOAN FUREY, RN, MA

Ms. FUREY. Thank you, Chairman Evans. It's a pleasure to be here to speak with you again about some of the issues that we are currently dealing with in women veterans' health care.

As most of you are undoubtedly aware, there has been considerable concern expressed by female veterans regarding the adequacy of health care services provided by the VA. Aside from a perceived lack in gender-specific services, there has also been concern expressed over the availability of psychiatric and psychological services specifically geared to treating the physical and psychological aftereffects of sexual assault and harassment that women veterans have been exposed to while on active duty.

Within the VA, the vast majority of the research and clinical work on Post-Traumatic Stress Disorder has been focused on the male war zone veterans. Research on women veterans and PTSD has been quite limited.

However, when we consider that the recent report, "Rape in America: A Report to the Nation," derived from data obtained from the 1990 National Women's Study, provides us with the first national empirical data about the forcible rape of women, it is obvious that this is a problem within our society in general.

The importance of further study and research on the impact of sexual assault on women and the resulting treatment needs cannot be overstated as it is relevant to both the mental and physical health care needs of women veterans.

The research findings of the 1990 Women's War Zone Exposure Study, on which I collaborated with Dr. Jessica Wolfe from the Boston Division of the National Center, surveyed over 200 women Vietnam-era veterans. It is important to note that this study was not done on a random sample of veterans, but, rather, on a self-selected group of women in that they were all involved in some way with veteran organizations.

However, the analysis of that data in the survey showed that, in addition to being exposed to significant stressors associated with a war zone setting, more than one in four of the female Vietnam veterans, 29.6 percent, surveyed had experienced at least one episode of sexual assault in Vietnam.

We also noted that those individuals who had been sexually assaulted had higher rates of PTSD than those women who were exposed to war zone stressors alone. Additionally, women with high-stressor exposure rates consistently endorsed more physical health problems than those with low exposure rates, a finding that is consistent with studies of the physical health practices of civilian rape victims.

Combined with the recent testimony by women veterans before the U.S. Senate Veterans' Affairs Committee in June and July of 1992, this gives us a clear indication that a percent of women veterans have been sexually assaulted while on active duty and are suffering psychological problems as a result of that experience.

Unfortunately, due to the lack of research on women military personnel, we do not know with any specificity what the incidence of sexual assault/harassment is in this population, which makes treatment planning difficult.

In 1991 the VA funded the first PTSD inpatient treatment program designed for women war zone veterans at the National Center's Palo Alto Division. Since our opening, we have received innumerable inquiries regarding the availability of both inpatient and outpatient services for sexual assault survivors.

Our own realization that women war zone veterans seeking treatment often reported similar experiences has resulted in our redesigning the program to accommodate the treatment needs of this population. To date we have provided treatment to women who served in both the Vietnam War and the Persian Gulf as well as veterans from the Korean War era and post-Vietnam era, who have been sexually assaulted.

Also the National Center recently funded the establishment of the Women's Health Sciences Division at the VA Medical Center in Boston under the direction of Dr. Wolfe. This division, the first of its kind in the Nation, will be devoted exclusively to researching and studying the effects of traumatic stress on women veterans' mental health and physical well-being, including the problems caused by sexual harassment and assault.

It is important to note, however, that the National Center received no additional increase in its annual budget to support this initiative, but, rather, cut out funds from their already established budget to support this initiative.

The Department has begun to recognize the need for increased training and education and sensitivity regarding women's issues and has begun training initiatives in this area.

A national training conference for VA health care providers was held in September of 1992. And since that time, many VA medical centers as well as Readjustment Counseling Service have held local conferences on women's health care issues.

Further, expansion of activities geared towards improving both the physical and psychological care available to women veterans has occurred in response to Public Law 102–585, the Veterans' Health Care Act of 1992. This law allocated $7.5 million to assist the VA in improving health care services for women veterans. Currently a variety of initiatives are underway to enhance both the clinical care and the educational program for women veterans' health care needs.

Finally, it is important to remember that the quality of any health care is dependent on the knowledge base that exists within the field. For this, we all depend upon clinically relevant research.

While the status of research related to women has received some attention from the VA, there is a great need for continued support in this area. And although Public Law 102–585 authorized $1.5 million to foster research relating to the health of women veterans, these funds have not yet been appropriated.

In summation, while it is evident that the VA has made progress in improving the health care available to women veterans over the past few years, it is essential that current efforts be sustained over time, new initiatives be developed, and deficiencies in women's health care be identified and addressed within reasonable time frames.

It is my hope that the committee will continue to focus on the needs of women veterans and that you will encourage and support enhancement of the VA's current programs as needed to ensure that women veterans receive the benefits and health services that they have earned.

Thank you.

[The prepared statement of Ms. Furey appears on p. 94.]

Mr. EVANS. Thank you, Joan.
Mr. Blecker.

STATEMENT OF MICHAEL BLECKER

Mr. BLECKER. Thank you.

I'm going to talk about the role of community-based organizations and then delivery of health care, especially as it relates to homeless veterans. It's hard to talk about that without starting a story. Most stories start "Once upon a time," so before that light goes off, I'm going to try to get through and summarize.

Swords have been around since 1974. When we started, we weren't the first nor the only. There's quite a few self-help organizations on the part of the self-help movement. We started. As an example, there were six VISTA volunteers working in the VA. They decided that there were some major issues, especially concerning Vietnam vets, that were not being addressed. That's why they decided to leave the VA and form their own organization.

As I said before, Swords wasn't the first nor the only. There was a book put out that was co-authored by David Adelstone in 1978. It was an ACLU book called "The Rights of Vets." They had a series of books, "Rights of Vets," "Rights of Women," et cetera. In that book, it essentially talked a lot about benefits for veterans and need to upgrade discharges.

They listed in the appendix all of the community-based organizations. There were hundreds of community-based organizations, hundreds. Very, very few of them have survived today, but there was a thriving network of those community-based organizations.

The reason they started was because they addressed key issues: incarcerated veterans. They addressed issues around substance abuse. They were culturally accessible, was the word. They were in storefronts. They were there where vets were. It was truly a help without hassles. It was truly a way to go in there without paperwork, without trying to deal with security guards and talking to someone who understood. And that's why they started.

In California there are names like Swords to Plowshares and Flower the Dragon, but, you know, that's California. But there are many of these CBOs. I would argue that when the vet center started its movement in 1980, they took the best features of that community-based movement with their storefront operations, their peer approach, vets helping vets, peer counseling, et cetera. Even the best people started that vet center movement.

Now, these community-based organizations got some funds, and their funding grew as they established more and more credibility in terms of as an effective service provider. In Swords' case, in other cases, there are funds from the churches, private foundations, Department of Labor, initially SETA, Job Training Partnership Act, the state departments of veterans affairs, block grants, membership special events, Department of Education, county health projects, just about everybody but the VA, even though this was helping veterans. That seemed a little bit odd, but, nevertheless, that was the relationship. And that was the role.

The key thing about these CBOs is that they were flexible, and they were in touch with their community. When we started realiz-

ing in 1982 that a lot of vets coming into Swords didn't have a roof over their head, we said "There's a problem." And over the years, that problem, among many problems, has ravaged our community.

Homelessness. Over a third of those who are homeless are veterans. Every day, every night, 250,000 vets do not have a place to stay. The issue is: What can we do about it? Because everybody knows there are limited resources to deal with that.

So what we decided to do—and initially what happened was the VA wasn't really addressing that problem until 1987, when they were actually given money for that purpose. That was the McKinney Act. That's when they started addressing the problem. There was a problem, they realized, in 1987. So they started providing health care.

Our problem was the money wasn't floating down to the communities. Instead of what homeless vets needed, which was residential care, too often it was a matter of case management and a lot of number counting and also not involving the rest of the community.

I think that spirit drove us, with much help from you congressmen, to look at it a different way, maybe some legislation. We talked about H.R. 5400. Basically, the spirit of that would be that it would require the VA to work in true collaboration with existing community service providers, it would talk about how to be cost-effective, including granting out to these community agencies, supporting them somehow, and also not to duplicate services.

So we are all hopeful of that. We work very hard. Unfortunately, the final law that came out, Public Law 102–590, stripped out a lot of that language, although it did have language about not duplication of services.

Now, what meant for San Francisco that the local experience was, I was just informed like two weeks ago, that the VA had received a grant under this award and was going to create a multi-service center, drop-in center, three blocks from Swords. We're at 15th and Valencia. And they're going to be, if you know the Mission District, a few blocks away in San Francisco.

Essentially we are going to basically get FTEEs. When you say VA and FTEEs, you feel like bowing down. That's like the homage to the FTEEs. It's a very magical, magical phrase. There's a certain thing that happens. But, anyway, they're going to have FTEEs to do a lot of case management right there beside Swords.

Now, the key thing was that there was no planning. We were not included, not just Swords or other groups, but there's very little outside San Francisco, nothing in Oakland, where there are huge concentrations of minority homeless vets. That was one problem. There's just no planning. So here in a very ineffective, cost-ineffective, manner, you have a duplication of services and, again, no money flowing out of the system.

The real tragedy is we're talking about homeless initiatives, which are probably a dot within the VA health care budget; I mean in terms of overall homeless initiatives, are a dot within that system. And, yet, this has come to be, which I just think is not going to serve vets. It would not really address the problem with such limited resources.

Thank you.

[The prepared statement of Mr. Blecker appears on p. 137.]

Mr. EVANS. Dr. Shay.

STATEMENT OF DR. JONATHAN SHAY

Dr. SHAY. Thank you, Mr. Chairman. It's an honor to address you, and it's an honor to be here with these people.

I am deeply ashamed that there are combat veterans who are not eligible for VA services and benefits. Virtually all of these veterans committed offenses after combat. This caused them to be discharged from military services under less than honorable conditions, what veterans call bad paper.

As an expert in Post-Traumatic Stress Disorder in Vietnam combat veterans, I can tell you that most combat veterans with bad paper committed infractions as a result of psychological injuries incurred in their war experience.

Typical offenses stemming directly from combat PTSD were: AWOL or desertion after returning to the United States, use of illicit drugs to self-medicate symptoms of PTSD, and impulsive assaults during explosive rages coming out on officers or NCOs, again, after returning to the United States.

These veterans had no treatment then and have no treatment now for their Post-Traumatic Stress Disorder or for its complications of substance abuse, depression, and violence. They have been profoundly disadvantaged in finding work and comprise a disproportionate fraction of homeless veterans, who make up one-third of all homeless men.

I am not asking for a study. I am not asking for an expansion of the existing case by case discharge upgrade program. Today I ask the Congress for a blanket upgrade of all veterans discharged under less than honorable conditions who have had any combat decoration, such as the CIB, CAR, or any equivalent in any other service, and obviously any award for heroism, such as a bronze star or silver star.

I have spoken to many Vietnam combat veterans with honorable discharges, and not one of them has felt that this would diminish them in any way. Stripping out some of the expletives, their reactions have all been either "It's about time" or "There but for the grace of God go I."

What I propose applies only to combat veterans, who constitute but a fraction of the 556,000 Vietnam-era veterans with general, undesirable, bad conduct, or dishonorable discharges. I estimate the number of Vietnam vets who would be eligible to be between 10,000 and 50,000. I have no estimate for other wars. And, clearly, the same upgrade should apply to every war.

I treat veterans with psychological injuries from their war service, and I find the situation of veterans with bad paper to be as unjust and irrational as if they had been drummed out for failure to stand at attention after their legs had been blown off. Most of these men, these combat veterans with bad paper, committed offenses because of their combat PTSD.

Pure self-interest should lead us to take this step, even if a sense of justice does not. Between a tenth and a quarter of all incarcerated males are veterans, although firm numbers on this are extraordinarily difficult to arrive at. It costs an average of $25,000 a year

for each one of these, not including the enormous monetary costs to society of the criminal acts themselves.

Unhealed combat PTSD predisposes to criminal justice involvement. The National Vietnam Veterans Readjustment Study (NVVRS) certainly demonstrated it. Treatment costs but a fraction of what it costs to wait for a crime to happen and then to use the police, the courts, and the prisons to "treat" it.

I see that the green light is still on, and I've come to the end of what I've prepared. Just to give you some numbers on violence, 36.8 percent of veterans with PTSD reported six or more violent acts in the preceding year in the NVVRS, compared to 11.5 percent in the demographically matched civilian control. Thirty-four percent of vets with PTSD reported two or more arrests, and 11 and a half percent reported conviction for a felony. In each instance, this was about three times what the rates were for the demographically matched civilian controls.

Thank you. It's been an honor and a pleasure.

[The prepared statement of Dr. Shay appears on p. 100.]

Mr. EVANS. Thank you, Doctor.

Mr. Quinlan.

STATEMENT OF WARREN QUINLAN, DIRECTOR OF OPERATIONS, NEW ENGLAND SHELTER FOR HOMELESS VETERANS

Mr. QUINLAN. Thank you, Mr. Chairman. Good morning, everybody. I'm very honored to be here, especially as a Vietnam combat veteran, today. I'm a proud American.

Somehow as a Nation, we made a mistake. I don't know how we can have highly decorated American warriors in this Nation after the fact dishonorably discharged or undesirables thrown away.

I'm the Director of Operations at the New England Shelter for Homeless Veterans. I've treated and help treat, path find for 3,000 veterans. I'd like to present the problems of combat veterans with bad paper from the perspective of having worked with those 3,000 homeless veterans who residenced for at least one night in the New England Shelter for Homeless Veterans during the last three years.

Separately, combat PTSD is a social and legal problem and veterans with bad paper are a social and legal problem. The two together produce a dangerous and intractable morass of criminal, civil, and domestic dreadfulness.

In the overall Vietnam-era veteran population of about 8.6 million, only three percent were discharged with bad conduct, undesirable, or dishonorable discharges. Yet, on any given day, an average of about 50 percent of the men coming through the doors of the New England Shelter for Homeless Veterans have such bad paper. Half or 25 percent of these are combat veterans. Since only nine percent of the overall Vietnam veteran population were combat veterans, what the shelter sees demonstrates nearly threefold amplification of social pathology that direct participation in war causes.

The shelter has as staff of volunteer lawyers and law students who assist homeless veterans with case by case discharge upgrades, but their experience is similar to the experience nationally, that

the existing case by case process takes an average of one and one-half years, comprising many separate administrative steps for the veteran.

Without legal assistance, no veteran can request and interpret the relevant regulations at the time and now, find and interpret the relevant case law and prepare a memorandum applying these to the facts, drawing the legally meaningful conclusion.

As a practical matter for a homeless man, this means that his prospects for upgrade, even with assistance, are essentially zero because of the extended time and multiple steps involved. To tell them that there is a case by case discharge upgrade program is a cruel joke. For them it is simply another sham, another lie told to them by the land which they fought for.

These men have no way out, no way up. If they receive psychiatric care at all, it is in overburdened State mental hospitals and municipal general hospitals, where they can expect little understanding of the distinctive problems of combat PTSD. The only reservoir of combat PTSD expertise, the VA, is closed to them because of their bad paper.

The first son heard his country's call to arms and fought in the Vietnam War, where his sweat, blood, and tears fell upon the jungle battlefield. The effects of the war took its toll on the first son, who was highly decorated for bravery; however, was discharged from the service with bad paper, conduct discharges, because he struck his commanding officer.

The second son served his country by protesting the war. He organized students, rallies, and marches to end what he strongly believed was an unjust war. When his country called him into the armed service, he fled to Canada.

Coming home for the first son was bitter. He encountered protesters at the airport who belittled him and spat on his face. On the other hand, the second son was blessed by the presidential pardon from President Carter. He was allowed to come home as a hero because his war was vindicated.

In the last three years, for the 3,000 men that have come through the door and for the combat American warrior that is so highly decorated, every time we try to help aid and assist him and we research his DD–214 and we look at all the citations and over in the corner there's a dishonorable or undesirable discharge, we're convinced that there's something wrong with this DD–214 and fax away a 180 form to Missouri to convince us that this is a misprint. And it's not.

I think we made a mistake as a Nation, and we've pardoned one son of America and we didn't pardon the other. Thank you very much for letting me be here.

[The prepared statement of Mr. Quinlan appears on p. 104.]

Mr. EVANS. Thank you. This panel has raised a number of issues. I'd just like to touch on a few and then open it up to my colleagues.

Michael, your testimony, of course, is very disturbing and indicates the VA is not only ignoring community-based veteran service providers, but wasting the scarce resources we have in order to duplicate existing services. Can you comment on the VA's apparent attitude toward these CBOs? What's the problem?

Mr. BLECKER. Well, I'll just use the example of the bill that we would—and it was scarce resources. We're talking about $10 million, but in light of 250,000 homeless veterans, it's a drop in the bucket.

What they need is a range of things, but obviously you need counseling and residential care. There's no dental care. They can't have access to that. These guys have serious dental issues, and they just can't get it anywhere. Obviously, they need employment. First they have to get housing.

I mean, that's an example of where the VA could, for instance, have said up here, "We have limited resources. And what we're going to do is try to figure out what's already out there and what's the best way that we can deal with the existing services, not duplicate services, what's in Oakland, what's in San Francisco, what's in the Bay area, what services are provided. Let's bring people together and figure out what we can do best."

The tragedy is in San Francisco it's a zero sum game because the services they put in San Francisco are services Swords will probably lose because there are cutbacks everywhere.

One of the key things is that everybody believes the VA takes care of vets. That comes down from the top level when you're trying to compete for funding to the bottom level, when the vet goes into a non-VA clinic. They find out he's a vet, and they immediately screen him out because of their cutbacks.

We're not even talking about health care. We're talking about employment. We're talking about legal services. Even trying to hustle up legislative support here, they say, "Well, there's VA here. And you guys have a $34 billion agency."

So what happens is I think veterans suffer by that perception. They suffer by virtue of no attention to their issues, and the individual vets suffer because they don't get the service they need.

So it's hard to say. I think sometimes the very presence of a CBO may even embarrass the VA because "Why isn't VA doing its job? Why have a CBO like Swords around?" I mean, those are just key issues.

In all respects, I think the bottom line should be: We're in a tight resource thing. What can we do most cost-effectively? A lot of times I would argue sometimes the VA uses a medical model when they don't have to. And that can inflate costs when you're trying to provide care.

I mean, I think that's what happened to the vet center in one extent. I think a lot of vets have left the vet center because they didn't have the Master's degree or professional degrees. What was missing was the fact that they were peers, vets helping vets. The vet can go on, "We're combat vets," and you're talking to another combat vet. That goes a long way to getting that rapport and trust. Trust I think is really important. That's why CBOs got started in the first place.

So I think there's an issue there with public relations, but I would like us just to compare costs. What can you do best with the limited money? I would guarantee the CBOs can do best. If they had just considered that, I think they would have gotten much, much more.

Just an example: In San Francisco, the whole regional office is moving from San Francisco to Oakland. And so the VA's health care homeless program was housed in the existing VA facility. So it wasn't costing money.

Now the rest of the VA is going to move into Oakland regional office, and they're going out and getting 10,000 square feet of space. They're going to pay money for that, increase staff. There are a lot of resources.

In the meantime, nothing is in Oakland. Nothing is in these outlying areas, where homeless vets' needs will go unaddressed. So I think that's a real tragedy.

Mr. EVANS. Did the VA consult with you? How did you learn about this?

Mr. BLECKER. They announced it at a meeting I was at. I knew they were going to submit an application, but we weren't invited to participate in that application or even what it was, what exactly they were going to apply for.

Mr. EVANS. All right. Thank you.

Joan, is Palo Alto still the only inpatient treatment unit for women?

Ms. FUREY. Yes.

Mr. EVANS. Are there any plans to expand to other facilities?

Ms. FUREY. I think as a result of the public law, there have been some proposals submitted by the field, which included supplementing about 60 vet centers with part-time counselors who are experienced in sexual assault counseling and developing four pilot programs from mental health and behavioral science that would provide expertise in these areas and then the four women's comprehensive health care centers, which have basically been mandated to include mental health services as part of a comprehensive care program.

But, again, when you talk four and four, you're talking about eight facilities nationwide and part-time people in 60 vet centers when there are close to 200. So it's certainly a start, but in terms of coverage, I think it's not going to really address the issue as it increases.

Personally I think that the issue of sexual assault among women veterans, that we are just really beginning to see what an issue this is and that it's going to start to broaden.

Mr. EVANS. My time is up. Let me yield to the gentleman from Pennsylvania.

Mr. RIDGE. Thank you very much, Mr. Chairman.

Mr. Blecker, I was impressed with your testimony and with the rather common sense approach you had to using limited resources. We've got finite resources. There are probably some days you think you've got an infinite problem you're trying to deal with and wonder why the government doesn't come to those who are already trying to deal with the problem in an effective way. It just absolutely is astonishing to me, and I'm certainly going to look into it.

I just wanted you to know that our friend and colleague Congressman Stump has introduced a sense of Congress resolution that says that, basically, if one-third of the homeless population are veterans, then at least a third of the McKinney money ought to be

targeted towards the veterans' community, which certainly seems to make sense.

I serve on the Banking Committee as well. And from time to time—you might just want to think about this and give me the benefit of your thoughts down the road. We do have the VA in an outreach program for veterans, and then you have the McKinney Act. And you've got existing entities with HUD trying to deal with the outreach to veterans and dealing with their homeless problems. If you had some thoughts on a better way to coordinate those kinds of activities, I would certainly like to hear from you or any of your colleagues.

We've set up two kinds of bureaucracies in Washington, provided jobs in Washington, staff in Washington, but if there's a better way that we could put the two together to put more resources and staff on the street to deal with homeless, I'd appreciate anything you might have in that regard. All right?

Mr. BLECKER. Thank you very much. I will. I'll consider that. And also with the National Coalition of Homeless Vets, I'm a member of that. We've opened up an office, and we can maybe put some energy in that.

See, one of the problems with CBO, you don't have a research and development part. And it's hard to really have a lot of resources, even though you do this work. It's very frustrating not to sort of be able to put it together and present kind of important information because that's where a lot of the exciting work takes place and solutions to the problems. But maybe through a national coalition we can put together some ideas, legislative ideas, or program approaches.

Mr. RIDGE. It might be something I may take up privately with my friend and Chairman here. If we can better streamline how the bureaucracy deals with getting the resources out to you we can deal with the problem. And I appreciate that.

Dr. Shay and Mr. Quinlan, your testimony is very compelling. I'm wondering if you would give me the benefit of the veterans' surveys' definition of combat veteran. In your assessment, Doctor, when you make those observations, you talk about combat veterans. What's the clinical definition or what's the definition you use?

Dr. SHAY. Well, the definition that I use for combat is the definition used in the Congressionally-mandated NVVRS, which is people who were exposed to a high level of combat stressors. This was composed of four elements: direct engagement with the enemy, exposure to abusive violence, deprivation, and a cluster of items relating to meaninglessness, the destruction of the moral context.

Mr. RIDGE. In your remarks, it seems to me that you took that basic definition and then suggested as you've looked at a lot of the DD–214's from some of these men with "bad paper," you found that there's a high incidence of combat-related activity, as exhibited by recognitions for valor and for service in what would be a high——

Dr. SHAY. I confess that I mainly had to rely on what counselors at the New England Shelter have told me. As a VA physician, I am barred from treating these men. They have their paper. They're not eligible for VA services.

Mr. RIDGE. So if this committee or I wanted to look to corroborate the conclusion, the generalization, the conclusion, you made with regard to combat veterans, bad—paper, high incidence—and maybe Mr. Quinlan can help us—of actual records that reflect combat experience, bravery in combat, which would corroborate your conclusion that it was that experience, that stressor, that led to the acting out of the PTSD manifestation when it was done, we would have to check with the outreach centers and the like?

Dr. SHAY. Yes, that's the most likely source of those data because they're the people that are seeing the men with bad paper, along with the prisons.

I must say I'm also relying on what men in my program have told me about themselves. Every one of them says "It could have been me" and they tell stories.

For example, one three-tour Airborne sergeant, when he came home had his 30-day leave and at the end of his 30-day leave just said "I quit." And he was AWOL for 93 days, which officially and according to the regulations, made him a deserter. He went back and turned himself in.

And, to make a long and actually rather funny story short, he was put up in front of a court-martial at Fort Benning, where the officers on the court were three officers, all of whom he had served with in Vietnam. And they said to him, "We can't do this. We can't throw you out of the service. Please give us a chance." He said, "Nope. I quit. Do what you want to me. I quit." Well, they worked him around, and he became a jump instructor at Benning and ended up as soldier of the year by the time his enlistment ended.

The sheer capriciousness of it all, had he had a different panel of officers, had they not been combat officers who knew this man, who had worked with him, had been on the radio with him several times a day, the outcome would have been totally different.

Mr. RIDGE. Thank you, Doctor. Thank you, Mr. Quinlan.

Mr. EVANS. The gentleman from Illinois.

OPENING STATEMENT OF HON. LUIS V. GUTIERREZ

Mr. GUTIERREZ. Thank you, Mr. Chairman.

I've had a great opportunity in the last couple of days to talk to groups of veterans. Yesterday was a very enlightening day, and I had dinner with a group from Massachusetts, some of whom are probably sitting back there somewhere. I know some of them are going to come and speak to us.

Coming from a district in Chicago where homelessness is a big issue, it was during the last two years that I realized the issue of veterans and homelessness. I guess one of the things that we need to do is to continue to learn about Vietnam veterans and the era and the veterans from that era because there just exists a huge amount of ignorance about it on my part, on other people's parts.

And one of the more enlightening points yesterday was just seeing how they're looked at from time to time and maybe back in the 1970s after the engagement was ending and people kind of saw everybody coming back from Vietnam as one and then we had the Rambo experience, a Vietnam veteran, and how it is we come to understand just who you are.

I think things are improving. I know as someone who didn't have a real good understanding about the era and the veterans from that era and someone who wants to learn about that and has over the last year, has learned about that and has become more sensitive to it, I think there is an opening in America.

People do care more. And I think if we show some courage and some willingness to challenge the system and some of the myths that exist out there, I think America is ready to follow and to continue the healing process that needs to occur with Vietnam-era veterans.

I would just like to ask. You know, we heard a big discussion in the last two months about the "pork barrel" politics of President Clinton's stimulus package. One of those was, of course, something that's apparently going to be eliminated, which is the community development block grant dollars. I know how they're used in Chicago and in the municipality in terms of—and some of it is used for basketball courts, for basketball courts in neighborhoods where, you know, they always say "We've got to get something for the kids to do. We've got to get them off the streets and the street corners, and we need to engage them in some positive activity. There are these adults, but there's no place to swim. And there's no place to play basketball. And there's no place to do anything except a lot of brick and mortar in the neighborhood."

So I'd like to ask any of the members of the panel about community development block grant dollars and what we might do because we'll continue to deal with them year in and year out.

Obviously the President wanted to add over a quarter of a billion additional dollars in the funds. I know for Chicago it would have meant an additional $60 million in one time only. That's just the City of Chicago. So I know what it could have meant. We could have dealt with veterans' organizations there.

What do you think? I feel that doing the outreach that the veterans need, we could do it with CBGD dollars.

Dr. SHAY. I would like to express my view, which is based on whatever small degree of expertise I can claim. And that is that when you're dealing with severe psychological injuries, where the capacity for trust has been destroyed and all of the violence and family pathology that flows from it, that the community-based treatment is the superior treatment. It is the superior treatment.

Yes, it also saves money, but you know something? I confess I don't care. What I do care is that it is a route to healing. The standard medical model usually fails.

So my view is that if you invest community development block grant money in your community-based organizations, that you will get an enormous return in terms of reduction of the social chaos and the human pain that comes from the inter-generational consequences of severe trauma.

Mr. MAY. I think it's important to recognize, too, that there exists in communities throughout this country a reservoir of talent and resources that are represented by Vietnam veterans, by other veterans, in our programs by people who address the needs of families where there's a member with a developmental disability. Part of the difficulty that programs have in doing what it is that they're best at doing is the serious resource limitation.

In our program I indicated we will have spent $65 million. To date we've provided services to somewhere between 80 and 100 thousand people at the cost of about $330 per case. Now, I don't know how that compares with the industry standard, but when you consider that the range of services that we pay for in communities ranges from information and referral to fairly comprehensive and sophisticated medical care, that strikes me as a pretty good number.

I recognize, as members of our advisory board and staff recognize, that there are other community resources out there who could do similar things for other targeted groups in the presence of sufficient resources to do these things.

I think it's incumbent upon all of us to engage in this paradigm shift and recognize that there's not much wisdom in reinventing the wheel. There are people out there who have expertise. What we need to do is see to it that they get the resources to do what they're most capable of doing.

Mr. GUTIERREZ. Let me just end by saying, Mr. Chairman, that I think that I would suggest yesterday in our discussions we learned about the Vietnam-era veterans and others. And we're going to need to cut back in some places.

Last night it was interesting after having dinner with a group of Vietnam veterans from the era, I went home, and I saw a commercial from one of the defense industries. It was a very nice commercial, and it was so interesting because it had John F. Kennedy in it and talking about the challenges. And at the end, it said we should have this manned spacecraft, that we should continue to challenge and we should have this person flying around the moon and up in the sky, and that we should put all our energies.

So I guess it was interesting. It was defense-related. It was John F. Kennedy. I had just met with a group of veterans from Massachusetts. And I really didn't care whether we had a manned spacecraft.

We've got so many men and women here on the planet earth that we need to take care of, and we need to make sure that each of you has a decent place to live and decent medical resources. And then maybe if there's money left over and they want to send one of the Vietnam-era veteran up there to check out what the world looks like, we'll do it.

But I just think we need to have a sense of priority. Yesterday was so fitting having dinner and talking about Vietnam and what happened and then going home and seeing what people want us to continue to do with billions of dollars.

Thank you, Mr. Chairman.

(Applause.)

Mr. EVANS. Thank you. I want to thank this panel for their excellent testimony.

Mr. EVANS. The members of our third panel are Mary Helen WhiteEagle, Gumersindo Gomez, Bill Lyons, and John Lopez. Mary Helen is an Army veteran.

Gumersindo is a decorated Vietnam veteran. Following his retirement from military service in 1988, he became Executive Director of the Puerto Rican Veteran's Association of Massachusetts.

Bill is a Vietnam veteran, a highly successful businessman, and is active in many civic and community affairs. He was recently recognized by the U.S. Small Business Administration as a veterans' advocate for the year.

John is Chairman of the Association of Service Disabled Veterans. This nonprofit organization seeks greater economic opportunities for our service-disabled veterans and prisoners of war.

Mary Helen, when you're seated, we'll start with you.

Mr. GUTIERREZ (presiding). Ms. WhiteEagle, if you would begin, please.

STATEMENTS OF MARY HELEN WHITEEAGLE; GUMERSINDO GOMEZ, EXECUTIVE DIRECTOR, PUERTO RICAN VETERAN'S ASSOCIATION OF MASS, INC.; WILLIAM C. LYONS; AND JOHN K. LOPEZ, CHAIRMAN, ASSOCIATION FOR SERVICE DISABLED VETERANS

STATEMENT OF MARY WHITEEAGLE

Ms. WHITEEAGLE. Thank you, Mr. Gutierrez. My name is Mary WhiteEagle. I'm a full-blooded Choctaw Indian from Mississippi. I have six veterans in my family, two females and four males, from World War I to the Vietnam era.

There is a need to sensitize the veterans' centers and the VA providers to the causal differences of the American Indians and the Alaska Natives. The greatest problem nationwide has been to get the veterans to come in for counseling. This is greatly due to the centers and service providers being in urban areas and are inaccessible to many veterans living on the reservations and in villages.

The centers need to be able to locate veterans within their state and area of operation, then employ a networking strategy with different American Indian and Alaska Native organizations and emphasize training programs for the reservations, villages, and islands and extend provider services to these veterans.

A demonstration of sensitivity and concern along with the ability to provide services or make referrals will make their credibility in American Indian and Alaska Native communities. I think there should be a clearinghouse if there isn't already one.

The need of all veterans, regardless of their cultural background, is to achieve some sort of integration of their combat experience. For American Indians and Alaska Natives, this need is particularly acute because the cultural emphasis on them is explicit, rather than implicit.

The veterans represent an extreme case both in terms of cultural preparation and reintegration opportunities and problems. Therefore, their experiences offer clinical observers difficult encounters.

The combat experience has established the warrior identification as a warrior clearly is valued by the community as a whole.

I myself am not a Vietnam-era veteran, but it is my concern for the benefits of these veterans that I am here. In 1992 a law was passed creating an Office of Chief Minority Affairs within the Department of Veterans Affairs. This just made the Indians and Alaska Natives and other indigenous people a minority within a minority. As far as I know, there is no American Indian, Alaska Native, or any indigenous people employed within this office.

Despite the fact that approximately 10,000 American Indians served in World War I, 25,000 in World War II joining the new recruits in Korea, and an estimated 42,000 American Indians and Alaska Native servicemen were stationed in Southeast Asia, very little attention has been given to the problems that have been incurred by these veterans.

Some of the research and studies that have been done since 1983 before and after say that the Indian veterans are outside the mainstream area, and they have considered the research insignificant.

The services of the VA have been inappropriate. As I said, in 1983 a study was done by a task force. And a very low percentage sought services within the centers. It is because only 62 percent of them knew of the different services that existed.

Some of the reasons to seek these services were: substance abuse, which was 10.6 percent; employment, 21 percent; Agent Orange, 6.4 percent; education 12.8 percent; discharge upgrade, 2.1 percent; violence, 4.3 percent; and a combination, 17 percent. But out of the percentages, only 55 were satisfied, 13 were not satisfied, and 32 percent had mixed satisfaction within the services that they received.

Numerous veterans have suffered stress-related symptoms and suffer from problems associated with their wartime experiences. Symptoms sufferers complain of feelings of rage, depression, spontaneous flashbacks of combat, and all other intrusive recollections, survivor guilt, and heightened startle responses.

In conclusion, I want to thank the committee, Mr. Gutierrez, for the opportunity to present my testimony. But let us not just say and not hear. Let us take the responsibility and accountability that has been given to us in our jobs.

Thank you.

[The prepared statement of Ms. WhiteEagle appears on p. 110.]

Mr. GUTIERREZ (presiding). Thank you.

Mr. Gomez.

STATEMENT OF GUMERSINDO GOMEZ

Mr. GOMEZ. Congressman Gutierrez, members of the committee, audience of fellow veterans, I would like to present on the need to provide opportunity for small businesses to Hispanic veterans. On behalf of the Board of Directors of the Puerto Rican Veteran's Association of Massachusetts and the Puerto Rican veterans of Massachusetts, we thank you and the committee to be able to do this presentation.

Because of the growing unemployment rate within the area that we serve our veterans, which is one of the highest in western Massachusetts, it is important to provide Hispanic veterans with the opportunity to start their own businesses. With this establishment of businesses, these veterans will be able to hire other veterans in their particular businesses or establishments.

We affirm very strongly that the economy of this country will be helped with small business within the community and the hiring of community people to work in these areas.

Since 1987 the effects of the economy in America have been painful and profound. More than six million permanent pink slips have

been handed out, and layoffs are occurring at an even faster pace this year than in 1992. Despite signs of a brisk economy, at least 87 large firms announced major job cuts in the first two months of 1993 alone, with us being surprised by today's paper, for those of you who have had a chance to read it today.

But for our Hispanic veterans, the established Small Business Offices located throughout the region are not the answer. Why? The lack of bilingual/bicultural personnel in these offices does not provide the sensitivity and reassurance that our veterans need to go through a process that is filled with red tape.

The way to proceed so our Hispanic veterans will have a chance in the system is through established agencies in the region that work with our community and that can render the type of guidance they need to achieve success in their business plans.

One of these agencies is the Brightwood Development Corporation in Springfield, MA. We, the Puerto Rican Veteran's Association, in conjunction with Brightwood Development Corporation have been successful in establishing two small businesses with veterans in the last year. We are currently working to establish two others, and the outlook is positive for them.

In conclusion, we ask that this committee consider ways in which financial aid from the Small Business Administration can find its way to the different community agencies that work with the Hispanic veterans and their families in order that our veterans get a chance to enter the small business world.

Thank you.

[The prepared statement of Mr. Gomez appears on p. 135.]

Mr. EVANS (presiding). Thank you, Mr. Gomez.

Mr. Lyons.

STATEMENT OF WILLIAM LYONS

Mr. LYONS. Good morning, Congressman. It is an honor and a privilege to be here before you this morning.

I come before you today to discuss two ideas. Neither of these ideas ask our government to spend any money. Both are ideas that are based on our need to create jobs, jobs that our veterans need and jobs that will give our citizens the opportunity to pay taxes.

First I would like to discuss Velda Sue. Velda Sue is an idea that would create an agency similar to the Federal National Mortgage Association. Velda Sue is intended to create a secondary market for the Small Business Administration-guaranteed loan. The ultimate purpose is to channel more capital into the SBA market. I strongly support this concept.

I have been a small business lender for most of my 20-year banking career. I can assure you that by channeling more capital into the SBA market, we will grow the economic base of our country.

I would like to share one concern and then look at creating a special investment vehicle under Velda Sue. In creating a secondary market in the residential mortgage area, we now have a monster called the standard loan. If you as a borrower do not fit the standard loan, you are in trouble. I am concerned because I have never seen a standard SBA loan.

This concept of the standard needs to be fully explored before we create a monster that's full of promise, but short of delivery. The veterans' community has a lot of experience with frustration, and Velda Sue need not add to that frustration.

I would also ask that as part of Velda Sue steps be taken to separate loans to veterans. This separation would allow for a special investment category. Investment managers at all levels, including veterans' organizations, mutual fund managers, and Wall Street could then give Americans the opportunity to directly support the veterans' community by investing in Velda Sue veteran loans.

We may even see a veterans' mutual loan fund. The loans would carry the SBA guaranty by being purchased at market rates and deliver much needed capital to the veterans' community. The potential for jobs to support the veteran entrepreneur and the growth of taxpaying citizens could be done without any direct Federal expense.

The second thing I want to discuss is the expansion of the Community Reinvestment Act to cover the veterans' community. The Citizens' Guide to the Community Reinvestment Act details 12 assessment factors. I've selected five factors that we can use to get the veterans some special consideration at the local bank.

SBA defines special consideration as follows, "In-depth management assistance counseling on first interview; two, prompt processing of a loan application of any type; three, in each district office, there shall be one or more loan officers designated as veterans' loan officers as a collateral duty; and, four, applications of veterans for business loans will be processed and funded ahead of other loan applications on the same day."

I can tell you from my experience in Buffalo that this is happening. Our local SBA office meets these definitions of special consideration and, in fact, goes beyond the letter of the law with an active, spirited attitude that makes dealing with them a pleasure.

I want to see the same consideration at the local bank. I would like to see the Community Reinvestment Act applied to veterans and the SBA loan guaranty program.

I believe that by expanding the coverage of the law that already exists, we can ask the private sector to buy into the need to put more capital into the veterans' community. In the following review of selected CRA assessment factors, I discuss the specifics.

Assessment Factor One calls for the banks to be active in the community and meet with community-based groups. What I know is that veterans frequently lose touch with their communities while they're away in service. I know I did. And their return to their community and in the business world is often colored by unrealistic expectations or bad information.

The recent downsizing in the armed forces will be putting large numbers of veterans back into the mainstream economy. I'd like to ask the local banks as part of the CRA to be more aggressive in meeting with veterans as they get out-processed.

Assessment Factor Two, the extent of the institution's marketing and special credit-related programs to make members of the community aware of the credit needs offered by the institution. The veteran generally has a special identification with another veteran. I would ask that banks be encouraged to appoint a veterans' loan

officer, much like the SBA does. I really do that in our community. I do most of the veteran loans. And so I know it will work.

Assessment Factor Eight, the institution's participation, including investments, in local community development and redevelopment projects. Many veteran community-based organizations do not have an established communication link with their local banks. I'm president of one of those as a volunteer.

Many of the CBOs need assistance in developing funds management programs. Banks could be encouraged to meet with CBOs to establish a dialogue that would open new doors.

Assessment Factor Number Nine, the institution's origination of residential mortgage loans, housing rehab loans, home improvement and small business or small farm loans within its community or the purchase of such loans. Again, SBA loans to veterans could be included as an additional statistical measure during a bank's examination. Veteran status is available in the standard SBA application.

Finally, Assessment Factor Ten, the institution's participation in governmentally insured, guaranteed, or subsidized loan programs. If we define special consideration according to the SBA SOP, purchasing of the Velda Sue loans that we defined as veteran loans could be included as a positive step.

In conclusion, what I really want to do is encourage the private sector to be more aggressive. I don't want to spend any more taxpayer money. We spend enough.

And I thank you for being here.

[The prepared statement of Mr. Lyons appears on p. 114.]

Mr. EVANS. Thank you.

Mr. Lopez.

STATEMENT OF JOHN LOPEZ

Mr. LOPEZ. Mr. Chairman, Mr. Gutierrez, and other members of the U.S. Congress and staff, I wish to thank you for this opportunity to present testimony regarding the concerns of the United States veteran.

I am a 43-year recipient of U.S. Navy medical care as well as the Department of Veterans Affairs medical care, but I will not be testifying on my life as a patient since I was originally injured in Korea.

The Association for Service Disabled Veterans is a nonprofit organization started in 1985 at Stanford, California. The ASDV, as we call it, has no paid staff. All support is by unpaid service-disabled and prisoner of war veteran volunteers and activity-specific donations by individuals and private sector corporations.

ASDV concentrates its activities on the needs and aspirations of those service-disabled and prisoner of war veterans that are supplementing their rehabilitation by being owners and managers of smaller businesses. In that respect, we have sponsored six State of California legislative acts pertaining to service-disabled veteran economic participation in State of California agency and related organization procurement policy. All of the sponsored acts are now chaptered sections of the California government code.

It has always been the mission of the U.S. Congress to oversight and advocate the needs and aspirations of those service-disabled veterans and persons our government has placed in harm's way. It has also been a special concern of the Congress to care and advocate for those subsequently maimed and tortured in service to the Nation.

There are various legislative efforts to assist the service-disabled and prisoner of war veterans to enable his rehabilitation into society through the use of medical advances, such as new prosthetics, new medications, and new care techniques. However, those service-disabled veterans that are attempting to enhance their rehabilitation by being owners and operators of smaller businesses are continuing to suffer discrimination from the federal government bureaucracy.

The U.S. Congress has previously passed several acts intended to assist and support the increased economic participation by service-disabled veterans and other disabled persons in the economy of the United States of America. Some of these acts, such as the Americans with Disabilities Act and the Veterans Act, have been severely compromised by regulatory fiat and bureaucratic discrimination.

Although the U.S. Congress has legislated and the Executive Branch has concurred that disabled persons as a group are to be considered socially, economically, educationally, and vocationally disadvantaged in Public Law 101–336, the federal bureaucracy refuses to accept that direction. It will not afford the service-disabled veteran participation in procurement programs directed to the disadvantaged population.

The U.S. Department of Transportation has not only refused to allow service-disabled veterans participation in direct Federal programs for the disadvantaged, but has also interfered with the attempts by the State of California legislature to provide support for service-disabled veterans in state programs. DOT has decreed that service-disabled veterans are not eligible for participation in state programs that are federally assisted, in contradiction to specific state legislation that directs service-disabled veteran participation.

The U.S. Department of Veterans Affairs has taken a similar course of action in its policies towards service-disabled veterans by declining to assist service-disabled veterans to participate in the U.S. Department of Veterans Affairs procurement programs. The U.S. Department of Veterans Affairs contends that they lack the congressional authorization to assist those service-disabled veterans seeking to maintain their rehabilitation by operating businesses, even though these veterans are actually the sole reason for the U.S. Department of Veterans Affairs' existence.

The U.S. General Services Administration has also stated when rejecting the requests of service-disabled veterans to participate in its procurement assistance programs for the disadvantaged that GSA regulatory interpretations do not permit service-disabled veteran participation in such programs.

This experience of rejection has also been the case in the following agencies and federally supported organizations: U.S. Department of Commerce, U.S. Department of Defense, Fannie Mae, the Resolution Trust Corporation, and others.

In all incidents of this discrimination and in all of the aforementioned agencies, there exists similar policies based on a presumption by one Federal agency: the Small Business Administration. The various Federal agencies, including the state and local agencies they financially assist, have all established policies that require that when contracting and procurement assistance to disadvantaged populations is to be provided, the agencies will follow the policy and practice of the SBA.

The SBA has determined that service-disabled veterans are not eligible when deciding which disadvantaged population members are worthy of eligibility for participation in special programs. Those presumed to be worthy are members of specific ethnic groups, including aliens from countries that have recently killed, maimed, and tortured over one million American servicemen.

Agencies have been very diligent in the inclusion of such non-citizen aliens as beneficiaries in their programs for the disadvantaged, but have denied such inclusion to those citizen veterans maimed and tortured in the preservation of freedom for all people, especially the citizens of this Nation.

Additionally, the SBA stated that service-disabled veterans are not worthy of participation in such programs unless they will relive and relate the horror, pain, and misery of their injuries and torture to the satisfaction of a panel of SBA employees. This is an outrage and an insult of barbaric proportions. It is also a gross violation of the Americans with Disabilities Act as the ADA defines who is to be considered disabled and that such disabled persons as a group are socially, economically, vocationally, and educationally disadvantaged and, therefore, entitled to all the benefits legislated for such populations.

Service-disabled veterans are unique in that they are the products of the actions of the Congress and the United States Executive Branch, and service-disabled veterans have an absolute right to be vigorously advocated by those officials who sent them to be killed, maimed, and tortured in the interests of this Nation, its programs, and its institutions.

Service-disabled veterans and prisoner of war veterans require legislative or presidential executive order action that will mandate that service-disabled veterans receive the same entitlements as are made available to other disadvantaged persons and groups.

Our Nation is presently experiencing an economic crisis that requires the participation, not exclusion, of all businesses in our Nation. The service-disabled veteran business owners of this Nation have previously sacrificed to protect this Nation, and they are ready to serve again.

I thank you for your attention. I will try to answer any questions that you may have regarding my testimony and the concerns it addresses. I have also appended further information for your attention and for that bloody light.

[The prepared statement of Mr. Lopez appears on p. 118.]

Mr. EVANS. Thank you, Mr. Lopez.

Ms. WhiteEagle, let me apologize that I had to step out, but I did read your testimony and am aware generally from what I've heard from other people in the community about the issue of VA sensitivity. Is there any program, veteran center program or other pro-

gram, that you think is doing a good job in outreaching to Native Americans?

Ms. WHITEEAGLE. Under Department of Interior, there is the BIA, Bureau of Indian Affairs. And their main objective, I believe, is to hire veterans. That's a plus.

Last year I went to a veteran center here on Capitol Street to apply for housing assistance. I was denied because I had not served so many years in active, but they didn't say anything about me being in the reserve.

As far as I know, all of the veterans—I guess about 46 percent are unemployed and are seeking employment.

Mr. EVANS. Is there any veteran center or other VA——

Ms. WHITEEAGLE. The only one I know is——

Mr. EVANS (continuing). Veteran center that's really made an effort, in your opinion, to be a model of where we might look at for some answers?

Ms. WHITEEAGLE. The only one I know is the American Indian Center. It's based out of Minneapolis, Minnesota, and another one, Vietnam Era Veteran Intertribal Cultural Association.

Mr. EVANS. Thank you.

Mr. Lyons, the concept of a secondary market for small business loans is a very interesting one. I think it raises a number of questions. Would this secondary market that you envision handle only SBA-guaranteed loans or would it handle other small business loans of any type made by a lender?

Mr. LYONS. The concept of Velda Sue right now is to handle all loans. I just want to have a subcategory within that for the veterans' loans so that Legion posts, VFWs that have access funds or anybody who would want to buy in and directly support the veterans' community could do that.

Mr. EVANS. Essentially calling for effectively more regulation of the banking industry in implementing this, how do you think the banking community would react?

Mr. LYONS. My experience for the CRA part of it is most of them are already doing it. The small community banks are very active in participating in a lot of community activities. I don't know that it calls for more regulation, just a little expansion of the definition.

When CRA first became a law in 1978, my experience at the bank I was with, we were already doing the things that the law asked for. So it wasn't very difficult for us to be part of it. In 1975 I was the Treasurer of Neighborhood Housing Services, before there was a CRA. So it doesn't pose a problem to me at all.

Mr. EVANS. Well, would investors be willing to invest in a package of small business loans?

Mr. LYONS. Right now they are. The 7(a) loans are being sold, the 85 percent guaranteed portion. In fact, my bank has funds to go buying SBA loans. In fact, I'm going from here this afternoon over to meet with the fellows over at the SBA office to talk about it and try to define it a little more.

There's a very active secondary market now in SBA loans. The Velda Sue concept just formalizes it and really just broadens it out to more accessibility to the public.

Mr. EVANS. Thank you.

Mr. Gomez, can you give us some additional information about the two small businesses which have been established? We're looking for models in the community-based organizations helping out to help us spread information that might help other communities. Can you tell us about those two small businesses that you've been able to help establish?

Mr. GOMEZ. Yes. We do have more information back home. What's good about this is that the people that we are dealing with, those veterans are people known to us and us known to them. And we can cut through that red tape.

Now, we have established this business without SBA loans. We have established these businesses with our Chamber of Commerce help, with private funds, and with city banks. But this just goes so far.

Now, if we can get some of that money that can filter down to those agencies, then we can do miracles because we have to deal where the rubber meets the road. If I take my people and I send them up—I had the opportunity myself to practice this.

I was going to buy me a big old business. I was visualizing millions of dollars in my pocket. So I had asked the SBA office, and I took a broker with me. I was not able to access it, Mr. Evans. I was not. I got so frustrated with it that I said, "The heck with it. Let's go back home, and continue doing what you're doing and continue to work. Forget the millions of dollars."

Now, that is me. I speak a little English, and I've got a little knowledge in the system. Just imagine my counterparts that have none of this, impossible for them.

Mr. EVANS. Thank you.

The gentleman from Illinois?

Mr. GUTIERREZ. Thank you, Mr. Chairman.

I really have enjoyed the testimony that we've heard. Maybe we should take a look at CRA, Mr. Lyons, because I just don't have as good a bank as your bank in many parts of my neighborhoods back in Chicago. They're not investing, and some of them don't care about the community.

I had a great experience back in—and I found out about it because I was a member of the Chicago City Council. The vice president of a nice bank decided I shouldn't be a member of the city council anymore, that he wanted to be. So I kind of asked about their CRA since he says I was doing such a lousy job in the city council getting people loans for houses. I went to find out that they had given no loans, his bank.

So we need to look at CRA. I want to take another look at it. I'm really grateful for your testimony. I think we have a great linkage here, Mr. Chairman. You know, we have Mr. Kennedy and Ms. Waters on the committee. We're on the Banking Committee, and we're always looking at CRA. We're all members of the Consumer Credit Subcommittee, which even gives us a little more. So, Mr. Lyons, we might be calling upon you.

I think we should have just a discussion maybe with the members that are on the Banking Committee to talk a little bit about Mr. Lyons and Mr. Lopez and just exactly what the Small Business Administration is requiring because it really startled me, Mr.

Lopez, what they're making veterans do, not giving them the loans, but in order to get the loans.

You said something about them having to tell about their experience. Could you tell me a little bit about that?

Mr. LOPEZ. Yes. In their loan instructions, "If applying for the direct loan program, please provide written documentation from a physician, psychiatrist, or professional counselor to confirm the permanent nature of the handicap and the limitation it places on the applicant." This is an insult.

The Department of Veterans Affairs and the pertinent military service, whether it's Navy, Army, Air Force, or, best of all, the Marine Corps, makes that determination before they separate you. And they do it very thoroughly with a panel of five physicians and one administrator.

To have a panel of SBA employees of Lord knows what level make a determination about your well-being and how much you suffer, I don't know whether they really want us to relate how many nights we scream in pain, how many pills we've taken.

I could tell them I've had 4,300 bed patient days. I think I cried most of those days because I was hurting. I don't know how many pills I've taken. I feel I am singularly responsible for making most of the drug companies in this country wealthy. I consider it just a total outrage.

Mr. GUTIERREZ. I think the government needs to take a look at that, Mr. Chairman, I think just to see if there's already a standard that's developed when these veterans leave the service. Then that document should just be provided, and that should be the beginning and the end of that.

Mr. EVANS. Will the gentleman yield?

Mr. GUTIERREZ. Yes.

Mr. EVANS. Actually, we have heard testimony in one of the other subcommittees that the Marine Corps and the Navy are starting to not give separation physicals to help determine disability claims. So that's one other issue we have to address as well.

Mr. GUTIERREZ. Thank you, Mr. Chairman.

My last point, I don't want my green light to go off. So I say hello to my fellow from Massachusetts. I went out there a couple of months ago, and we talked a lot. One of the things we talked about a lot was the veterans. I want to commend you on the fine work you're doing, Mr. Gomez. I wasn't here to listen to Mr. Rodriguez earlier. I know he's out there. Hello.

I'm enjoying the book very much. I got the first chapter in last night. Those are small presents that I've been receiving on veterans. They're educating me. They're giving me books, and I really appreciate that, that you're taking the time to educate. I just wish every other member of Congress would have good constituents that could give them books and educate them and that's all they would get from them, their books.

I wanted to say, Mr. Gomez, you know, the sensitivity issue for the Hispanic veterans is very, very important. And I'm happy you brought up the issue of language. In America we have this great system that when—the Latinos, usually they know we speak Spanish. So we don't have to go around bragging about it or bringing

out little brown ones during the campaigns and tell everybody about how our family is so sensitive.

But it seems that politicians when they want to get elected and they want votes from different constituent groups, they will maybe say a few words in Spanish, maybe bring up a little brown one in their family, tell them how broad-based their family is. They'll do all kinds of things to kind of woo the vote.

Then government should just be as responsive after the election in terms of providing the services to that community that has a deficiency in that language. Not only during the election when they need your vote should you speak Spanish. You should speak Spanish in order to deliver the services that are required so that government can be responsive to those needs. Of course, they forget Spanish the day after the election or whatever few words they learn.

I want to thank you for bringing that issue up, and I'd like you to talk a little bit about the Puerto Rican and the Latino veteran, the need for language and cultural?

Mr. GOMEZ. I definitely thank you, Mr. Gutierrez. Let me share with you a vivid experience that I went through in 1966, when I decided to join the U.S. Army. You see, I was not called. I volunteered. I wanted to go. I knew that Vietnam was going on.

When I arrived in basic training, two or three days into my training the drill sergeant came to me and said, "Gomez, do you want to do KP?" I say, "Yes." I wanted to look good, you know. I was pumped up. When I spent 12, 13, 14 hours in the kitchen washing pots and pans, I said, "My next answer is no." So about two or three days later, he came to me, "Gomez, do you want to do KP again?" I said, "No, no." And I learned English very quick.

This is a situation that we have now with our veteran counterpart that comes from Puerto Rico. Fifty-eight thousand came from Puerto Rico to go into the Vietnam War, just from Puerto Rico. I go into New York, and hundreds of thousands of others joined or were drafted from the States. So that 58,000 went way high. We, the Puerto Rican people, out of the island, provided the most service people out of all the continent of the United States into the Vietnam War.

Now, those people decided to go back home because that was home. That is home. Every good Puerto Rican wants to be buried in Puerto Rico. So they forgot the language because they had no need to practice that language. Yet, they learned a little language in the service to get by and to do their time. Those of us who decided to stay in, like me, just learned a little bit more.

Now, what has happened with those people? In Puerto Rico the services, as the Chair here knows, are very poor. Mr. Gutierrez, who every year brings his father into the continent so he can be checked out in the VA system here in the United States, also knows what I'm talking about. So those people have to migrate to the United States to get those services that they so badly need.

If you are a service-connected individual in Puerto Rico, you might be all right. If you are a non-service-connected disabled individual, forget it. You will not get through the door. So those folks have to come over here.

They have learned of the Puerto Rico Veteran's Association in Puerto Rico, and we are trying to serve as many as we can out

there. Now, what happens when they get here? There are no professionals, as Mr. Rodriguez testified here earlier this morning, to see these people.

I walked in with one of my veterans to see a psychiatrist. He did not know who I was. When he said, "What are you doing here?"; I said "I'm going to be the translator." He said, "Tell your veteran to go back to Puerto Rico and get the services over there or tell him to learn the English. I need to talk to him. I cannot talk to you." In part, he was right, but he got a piece of myself. I was very frustrated with this.

And this is happening. Now our people are not accessing those services because there are no professionals. There's nobody to meet them at the door and say, "I talk your language. I can understand what you want, and I can take you through the system."

I have to do this, and I'm only one man. And there's only one Puerto Rican Veteran's Association in the United States of America.

Mr. GUTIERREZ. Thank you very much, Mr. Gomez.

Mr. EVANS. The Chair thanks this panel for very good testimony.

Members of our final panel are Karen Johnson, Rear Admiral Norman Johnson, and Frank Falkowski. Karen is a decorated Vietnam Army veteran and attorney in private practice in Little Rock, Arkansas and active in many community and civic affairs.

Norman is a retired naval officer and currently serves as Vice President and the Dean of Students, Boston University. Welcome before the committee again.

Frank is a Vietnam veteran who currently serves as the Chief Operating Officer, Western New York Veterans' Housing Coalition Incorporated. It's good to see Frank again.

We'll start with Karen once everybody is situated here.

STATEMENTS OF KAREN JOHNSON; FRANK J. FALKOWSKI, CHIEF OPERATING OFFICER, WESTERN NEW YORK VETERAN'S HOUSING COALITION INC., ACCOMPANIED BY JOSE L. FUENTES, CAC, PROGRAM DIRECTOR, WESTERN NEW YORK VETERAN'S HOUSING COALITION INC. MAYDAY HOUSE; AND W. NORMAN JOHNSON, REAR ADMIRAL, USN (RET.), VICE PRESIDENT AND DEAN OF STUDENTS, BOSTON UNIVERSITY

STATEMENT OF KAREN JOHNSON

Ms. KAREN JOHNSON. Good morning, Mr. Chairman. I come before the panel today not as an expert. I have no titles behind my name other than Vietnam veteran. I do not work for the VA, but I do use their services on a daily basis. I have done this since I got out of the services in 1980. So the only experience I have to talk to you about is mine and the other women veterans who have come to me. We have established ourselves as veterans' advocacy persons in the community.

In 1981 I was hospitalized in the VA Hospital in Little Rock, in the older facilities, for 30 days. They had to clean out a ward that was a four-bed ward so that it would have a place for a woman to have appropriate facilities. Because of that, three other veterans were discharged or moved down the hall and could not receive services. It made me feel somewhat inadequate that one person was

taking the place of four. They had no bathroom facilities and no way to take care of the problems that related to your gender.

In 1985, graciously, the Congress appropriated the money, and a new hospital was built in Little Rock.

Two months ago I, unfortunately, got to receive some of Dr. Klimberg's services. I went over to our new facility that had designated female rooms. Well, they were filled with men because they were the ones with the private bathrooms. So for a hernia surgery, I was placed in the neurosurgery ward and affectionately referred to it as "our neuro hernia."

There were two other female veterans who were hospitalized at the same time, one of which was a Gulf veteran who is a paraplegic who was there in her wheelchair. She told me she was very, very lonely, that she was away from her family. She had to travel hundreds of miles to come there. She was having a reversal of a colostomy.

She was in a room that had no window. It had no bathroom because the one female room on the ward was taken up even before I arrived. I had to wait until 9:30 that night to take a surgical shower because I had to wait until the other person had been showered. And then they had to go in, and you could go down and use the same bathroom because there were no facilities to do this.

This is our new $9 million VA Hospital that is supposed to be user-friendly for females. I can't see that our $170 million to go to the use of two VA hospitals in Little Rock in the 12 years that expired between my use of these services have really progressed much, not to mention the fact that I'm still wearing men's pajamas.

These are simple things, pulling the curtains in the clinics. Why did they put the women's clinics on the ground floor in front of the parking lot and with the adequate lighting? It makes it really difficult to use the facilities if they were there.

I'm also the recipient of a person who was sent out for a basic mammogram that was then lost in transmission between the facility that gave me the mammogram and back into the facility that was supposed to read the mammogram and do something about it for over a year, which it indicated the suspicious nature and called for further tests.

Fortunately, it was benign because if you understand anything about how cancer grows, you know it starts with one cell, and it doubles itself every 100 days. It takes approximately six years for this cell-growing process before it could be spotted on a mammogram, but within about seven years, you could find it with self-examination. That's because of this doubling process.

So waiting a year for your mammogram results that the taxpayer has already paid for to come back doesn't do a woman very much good. It's going to be beyond treatment. I could just as easily have been standing before you today as a mastectomy patient getting prosthetic treatment from you.

I'm also here as a small business owner. I can't get a small business loan. They're not funded. In addition, women generally are in the lower-paying jobs. They don't have any management experience. The Glass Ceiling theory applies.

When you go to the SBA, you have already heard the testimony about what the forms say, "List all of your experience. List all of your disabilities." We don't quality for 8(a) set-aside funds because we're not socially handicapped. And to prove it is an outrageous process that you have to go through.

If women veterans in general cannot get the care in the facility because the care is not there or you don't want to have the type of care that's being provided, if you can't go out and go into business for yourself, then you're going to be doomed to the treadmill, low-paying jobs where you're totally dependent on what the employer can give you for health insurance to go out into the private sector.

You've heard Dr. Klimberg's testimony that says many women veterans are not receiving any treatment at all. That is an outrage to me. They're not getting at the private sector. We're not providing it to the government, even though it's been mandated over and over and over. These are not new mandates. These are old mandates. They're still not being funded or fulfilled.

I don't know what the answer is, but one thing that has become painfully clear to me is that without statistics, you don't get any. Since there have been no statistics developed for women veterans because you tell us that, gee, we don't use the facilities and so we can't gather any statistics and if we do go in to use the facilities, there aren't any statistics because there were no statistics to build the facilities for us to use.

I don't know where we're going to stop this vicious circle, but I would suggest that it would be today and that we fully fund a women's treatment center and a pilot program and that we put a process in place in the Department of Veterans Affairs to gather these types of statistics that are needed so that we can come before this committee next year and tell you what those statistics are.

[The prepared statement of Ms. Johnson appears on p. 124.]

Mr. EVANS. Karen, thank you.

Mr. Falkowski.

STATEMENT OF FRANK FALKOWSKI

Mr. FALKOWSKI. Thank you, Mr. Chairman. I appreciate the opportunity to come forth and give a situation report on the activities of the veterans' community in western New York.

As you know, I've been involved with the conference for over ten years. Much of the success of our coalition in western New York has been through the resources and the education and the commitment of the members of this conference. In fact, I understand that some of us have been labeled "mavericks."

Though I kind of appreciate that term, as you are hearing today, much of the ammunition that we have been getting from the federal bureaucracies that we deal with has been loaded. Therefore, we come back every year with some of the same issues.

In my previous testimony a couple of years ago, I shared with the committee how our corporation started with a $1,500 loan from United Way or a grant from United Way and took a 4-story building and rehabbed it at a cost of $1.2 million.

Our coalition now is basically serving two functions: development of accessible affordable housing for disabled veterans and homeless

veterans, and in conjunction with that, we have a case management component to that.

I would like to briefly share with you some of the things that I have been experiencing on the development side because much of what we have done, our agency has put the neck on the block to developing these kinds of projects to the tune of $5 million this year. Many of our colleagues across the country are also doing this kind of housing development.

What I'm experiencing is why the cost containment issues that come up; for example, HUD has some cost containment criteria relative to their 202–811 programs for physically handicapped buildings, which we are putting up a 24-unit building in Buffalo.

Many of these cost containment issues are just absolutely insane. I mean, I understand the need for cost containment, but when you're building a facility for physically challenged people, you should be building a facility that's going to be very useable for them.

In many cases we have gray areas in the ADA law, which become fights between the federal government, the State inspections, and municipalities, which lead to cost overruns, which lead to change orders, which we as the workers, the developers, are responsible for.

We also have a situation on the shelter side, the homeless programs that we provide in Buffalo, relative to the HCMI program, which is the VA's program for, not that I appreciate this term, homeless chronically mentally ill.

Though a portion of our resident homeless veterans do fall into drug, alcohol, and mental illness, we're seeing a very high proportion of dislocated veterans who have lost their jobs. We are seeing Desert Storm veterans who have been sheltered in our programs. We are seeing female veterans who have lost their jobs that are single mothers coming through our program. And I cannot fill these beds fast enough.

So we engage with an HCMI contract with the VA, which was part of their latest partnership, which I am all for, a partnership between the VA and the community-based organizations, basically because we were more effective in the delivery of services and because we were developing housing to place these individuals.

What I'm seeing now is veterans who are handicapped, both physically and mentally, stuck on hospital wards because they do not have accessible housing.

I'm seeing veterans going through 21-day treatment, drug, alcohol treatment centers, and being discharged from the VA to the street, back to the Salvation Army or other small term or short-terms agencies.

They all need to come back into the system so that revolving door system is going on. I recently have been notified by our VA in Buffalo that they have received some Federal monies to hire under they HCMI program employment and training reps.

I'm getting a little bit confused about what the role of the VA is in these issue areas. Why is the VA getting involved with employment and training when we have the Private Industry Council, we have the DVOPs in a local area that can more than handle and network these kinds of issues?

So I wanted to bring some of these issues to your attention, both on the operational side, because being one of the last speakers here, everything my colleagues have been expressing are concerns we share with them.

However, when you get to the point where you have so much money on the table and are responsible to a board of directors for $7 million in development, these issues become very gray because they create a cash flow problem.

And, as you know, not many not-for-profit organizations have unrestricted monies, development monies, the cost of doing business like some of the small businesses in the private sector do. So these are issues that are very costly. They waste public dollars. And I think the arrangement between the VA and the CBOs is critical because we do it cheaper and we're more cost-effective.

When you look at the 300 or 400-dollar a day beds in a hospital versus small per diem rates to house these individuals, long-term, and integrate them back into the system, I think we're much more cost-effective.

So if we are mavericks, so be it. We will continue to be so until we resolve the issue of homelessness, of which 30 percent of our homeless population in New York State are veterans.

Thank you.

[The prepared statement of Mr. Falkowski appears on p. 126.]

Mr. EVANS. Thank you.

Admiral.

STATEMENT OF W. NORMAN JOHNSON, REAR ADMIRAL, USN (RET.)

Admiral JOHNSON. Thank you, Mr. Chairman.

Since my testimony before this subcommittee on September the 23rd, 1992, a great deal has transpired in the First in Peace program. To refresh your memories, First in Peace is a program at Boston University that will employ unemployed young veterans as mentors and educators for inner-city adolescents who are wards of the state or homeless.

Our veteran cadre will live with the youth participants in military housing and will have access to recreational and educational facilities at closed or closing military bases. In addition, the veterans will accompany these young people to their inner-city schools daily and will serve as teachers' aides, security personnel or in any other role that the principal decides can best support the school's mission.

After a great deal of publicity, First in Peace received the attention of the White House and the Office of National Service. In essence, we have traveled from an idea in September, 1992 to a comprehensive operation proposal with a prospective client: the Federal Government.

Accordingly, at the request of the White House in March 1993, I presented the First in Peace concept to a group consisting of representatives of: the Office of National Service, the Office of Veterans Affairs, the Joint Chiefs of Staff, the Commission on National and Community Service, the National Guard, and staffers from the of-

fices of Senators Boren and Wofford, the legislators who sponsored the Civilian Community Corps legislation.

The Office of National Service hoped to fund Boston University's prototype under the demonstration rubric of the CCC legislation. That prototype would engage veterans and inner-city young, ages 14 to 18, in residences on closing bases near Boston.

The Boston University model would provide jobs for 25 veterans and 100 students at Fort Devens. The model has an educational component for the students consisting of 160 hours: 90 in classes on reading, math, life skills, and career choices.

They will also spend 60 hours engaged in community service, much of which has a strong apprenticeship component that could lead to employment.

Veterans would also receive 75 hours of classroom education, which would include resume writing, career choices, and computer skills such as spreadsheets, database management, and the like.

Despite genuine enthusiasm for the proposal, the National Service Office could not go forward with the demonstration for the reasons cited in this letter by Director Eli Segal, The White House, April 16, 1993, Dear Dean Johnson:

"I am writing on behalf of all of us who had the opportunity to review the outstanding proposal you submitted for a Civilian Community Corps demonstration program using military facilities on the base closure list as a residential site and military veterans as the supervising cadre for a service oriented program targeting disadvantaged youth. Unfortunately, specific legal obstacles prevented the Commission on National and Community Service from being able to sole-source a CCC summer demonstration project.

"However, everyone in my office and at the Commission who looked at your First in Peace effort and your summer proposal readily recognized the potential, conceptual integrity and programmatic efficiency of both concepts. These concepts underscore the tremendous effort you have put into serving your community, and I hope that as we move forward in developing and designing the CCC program, we can call on your expertise and advice.

"I wish you well in your efforts to realize First in Peace and hope that we can continue our dialogue on the best ways to reach out to our communities and make for a better America. Thanks again.

"Sincerely, Eli J. Segal, Assistant to the President and Director, Office of National Service."

That setback notwithstanding, the First in Peace model has considerable momentum, and it would be negligence on the part of the university and the Nation's leaders to let it slip away. I intend to bring the proposal to the attention of the many foundations, businesses, and individuals who have already corresponded with me indicating their willingness to help fund such an effort.

With this private support, we still hope to test the model and its potential to provide the necessary jobs, education, and improved quality of life for both veterans and students. We also plan to demonstrate that this model can do all of those things at a significantly lower cost than any of the competing alternatives.

It is worth noting that the jobs in the recently killed $6 billion presidential economic stimulation program, which also had a

summer jobs component, would have cost $89,000 per individual; whereas, Boston University's First in Peace program would do the same thing for $3,900 per individual, or 4.4 percent of the government's projected cost per person. This economy alone makes the effort worth pursuing, and it is on that basis we are seeking this committee's continued and vocal support.

Frankly, given the administrative logjam that seems to characterize so much of the current bureaucratic environment, substantive forward movement through the offices of any of the obvious agencies we might ordinarily turn to for support seems highly unlikely indeed.

Clearly the Department of Veterans Affairs has its own agenda. The Director of Veterans Assistance Service recently sent me this interesting observation in a letter responding to one of my letters. I quote, "As you may know, VA is involved in several initiatives to assist active duty military personnel in their transition to the civilian sector following their release from the armed forces. VA is a partner agency with the Department of Labor and the Department of Defense in the Transition Assistance Program.

"In addition, the Service Members Occupational Conversion and Training Act of 1992, will be implemented in the very near future. This program is designed to assist veterans through a job training program developed by private employers. The program is being implemented jointly by DOD, DOL, and VA.

"Your proposal does have merit but does not directly correlate with any of the programs described above. Further, I do not believe that your proposals falls within the purview of VA," unquote.

Well, maybe not. And then again perhaps it does. It depends, in large measure, on how creative, entrepreneurial and helpful the VA wants to be.

My distinct sense is that the VA has its own agenda, and so do the other agencies with similar interests. If the things already in place are not moving—and many are not—it seems a distinct pity that other things that are ready to move have to go through so much to find a place.

This subcommittee can take some important steps to change that situation. And I sincerely hope that one of them is a strong reaffirmation of a promising, economical, and reputable program between our veterans, our youth, and our country, a program that with your help can truly become first in peace.

Thank you very much.

[The prepared statement of Admiral Johnson appears on p. 133.]

Mr. EVANS. Thank you, Admiral. Let me just start with you in terms of your program. We're going to have a lot of talk here, and I can understand a national service bill is going to be introduced. There's a lot of controversy built around that.

The President's program, as I understand it, attempts to give college assistance to people, either before or after they go to college. Your program is to help veterans in terms of being role models and mentors for these youth, but also to reach out to youth before they have significant problems in some of their hometown communities.

Can you tell us a little bit more about the program, some of the services that you provide as well as helping these kids?

Admiral JOHNSON. Well, surely. I'm tied into many grass-roots organizations, but since you mentioned the National Service Program, that gets $5,000, and it's on a without-need basis.

The way we're going now with our young people, we'll never have them unless we improve their education. They won't be capable of getting those monies, because they won't be educationally qualified. So, you have a section of the middle class or above on a without-need basis who can get $5,000 towards their education for two years in exchange for two years' service.

And there's a great deal of difference between two years' service coming home every night to get $10,000 for two years of college and two years having an M–16 and walking around Somalia or kicking something out of the back of an airplane in Yugoslavia. There's a tremendous difference. You can call that difference courage.

That's why I think we have to do something not only for the veterans for employment, but also for the young kids age 14 to 18 who are wards of the state, because in America we do not have any programs for kids 13 to 18 unless they get in trouble.

I think that using the military, the veterans, and at the same time giving them skills through special lectures, Small Business Administration lectures because a lot of them are machinists—they could take a lathe, put it in the garage, and go into business. Ninety percent of our jobs come from small businesses.

So I think we should use their skills. And many of them are teachers. They've taught at the service academies. They've taught at the ROTCs at Boston University. And they're getting out.

These are useful skills. We, the taxpayers, paid for these skills. These are national assets. So I believe that we can get apprenticeship programs. All of those bases have maintenance facilities, airplane maintenance facilities, plumbing, carpentry, and those people that are coming out as veterans are skilled in these trades. They can at least take the kids there on Saturday and Sunday, or sometime when they're not in school, and show them what goes on. Maybe they'll learn how to change a faucet washer. Maybe it will be interesting for them to work in other fields from their experience.

There are a lot of possibilities by using equipment what we already have. Maybe we can get them interested by using what we already have and not trying to purchase more.

Mr. EVANS. Well, those veterans are going to be coming home to a less than sluggish economy themselves. The President is talking about additional law enforcement personnel. I would hope that perhaps through some programs like this we would be able to put people into helping people directly, instead of dealing with them once some crimes have been committed or whatever. So I appreciate it.

I'd like to address some of the other issues and some of the other questions. Karen, we're going to have a hearing on women veterans, mostly focusing on the health care issues, but it will also examine other issues and we'll be looking into small business loans as well.

Frank, have you had the same kinds of problems, lack of coordination with other Federal agencies and non-response from the VA as far as you're concerned?

Mr. FALKOWSKI. Well, our experience with the VA has been purely on the HCMI. We started out on pretty good footing in 1990, when we started our first contract. Now I'm starting to see things like we have a contract for a per diem per day for 12 beds.

The VA now has cut back on my beds, telling me that they're not sure about the extra pot of money that's supposed to be allocated for HCMI. The bottom line is that I prepared a budget. They want 24-hour staffing. That's not cheap. They reduced my beds from 12 to seven, and seven is my break-even figure just to make payroll. There are some control things that seem to be going on.

From what I understand during the point of the conference, some of my colleagues are having the same issues with the agency and in my program on the development side some of the same things on cost containment and ADA, gray areas in the law.

So that's why I mentioned it, because relative to the case management and providing services to the homeless, the experiences that have been shared with you today are the same that I'm experiencing in Buffalo. It's been getting a little bit better, but it's only through the maverick spirit that we have not to stop.

The homeless situation is not going away. Obviously with the number of people that have attended this conference, it's growing and growing. With the new veterans coming out of the service, especially you're going to see economically dislocated veterans coming out.

That's why I've been seeing from Desert Storm and things and from other eras that there are just no jobs. You don't have any job. You don't get your mortgage. You end up on the street. It's a snowballing effect.

So I expect to be in business for a long time, unfortunately.

Mr. EVANS. After Mike Blecker had testified, I talked to Congressman Ridge. He also, I think would be helpful in doing what we talked about yesterday at the conference trying to set up a roundtable with the various agencies and the new people coming into the administration to see if we couldn't talk through some of these problems and establish a dialogue.

So as soon as we put that together, we'd be glad to get back to you.

Mr. FALKOWSKI. For the record, Mr. Chairman, I'd like to point out that the Joiner Center has been very instrumental over the last ten years. I can't think of a better forum to initiate some kind of task force or brain trust, whatever you want to call it, because I know it has worked for our organization and I'm sure it has worked for many.

This is not a matter of what organization you belong to or have an allegiance. It's a matter of dealing services to our veterans who serve their country, and I think that's the bottom line.

Mr. EVANS. Thank you.

Gentleman from Illinois?

Mr. GUTIERREZ. Thank you very much, Mr. Chairman. I would like to echo Frank's sentiments on the Joiner Center. We have maybe a beginning point to have these types of discussions and, Mr. Chairman, getting involved with HUD and all of the people who have to deal with housing so that we can take a look at housing and the kinds of programs. They were all impacted.

We know that homes for senior citizens, which is a growing and growing population, not only will they have all of us, at least Frank and I who are the baby boomers, there are going to be more and more of us. Maybe we should all remember we're all going to get old one day and we're all going to need housing and the kinds of services.

We see the kinds of cutbacks. So we really need to look. We need to integrate those so that given the limited resources that we have—one of the good things about being on this subcommittee and being on the committee is making you aware of veterans' issues and in treating veterans as they are in terms of their professionalism.

I mean, we have a rear admiral here. Maybe he doesn't have the problem, but a lot of times people just look at veterans as veterans instead of looking at them as engineers and doctors and qualified people in this society to make change and improve the quality and standard of life.

We have to be careful. "They don't care about America and what's going on," but, of course, they were good enough to give us the America that we have and the kinds of freedoms that we have. So I think we need to change a lot of this attitude adjustment.

And I'm really happy that the rear admiral has brought up a program. Maybe, Mr. Chairman, we should discuss it at a later point. President Clinton's office is going to come out with a 100,000 community police force throughout America. We're going to bring back people from Somalia. We're going to bring back people that have served.

Maybe the same way we looked at the program for national service, we should look at and begin to address a sense of the Veterans' Committee and letting the President know real early on before he goes any further in that program, that 100,000 men and women across America that we intend to put on our streets to be in touch with people to make our communities safer places to live and more valuable community. I think given the admiral's suggestion on that point, your suggestion about that.

So I want to thank all of you for your work. Then last week on the Subcommittee on Hospitals and Veterans, Paul Egan from the Vietnam Veterans of America reminded us all that, this committee and all the members of this committee, that we're really like the board of directors of the VA medical system, that we should take our responsibilities seriously as members of the board of directors of that.

I think in that role, I'd like to touch a little bit upon health care. I'm going to go to Ms. Johnson just for a moment because your testimony and much of the testimony that we're talking about competing, the VA is going to have to compete.

There is this understanding and this sense of members of Congress and members of this committee that health care reform is coming, but given the special needs and special considerations of veterans here in this country, we are going to preserve the veteran and the VA hospital as something special and unique given the special needs of veterans, even though everyone thinks we're going to do this whole revamp of our health care system.

If we're going to do that, the question comes up: Now people will have two cards. They will have a card that is given to them on their health care reform where they as American citizens can access any health care facility. And as veterans, they'll be able to access the veterans' facilities.

What kinds of things are we going to need to do? What are the veterans and women in terms of prenatal care and the kinds of issues about bringing children into the world? How do you see it competing? Do you think that veterans are just going to leave the VA altogether once that health care reform comes?

Ms. KAREN JOHNSON. I don't think the veterans are going to leave the health care system, but there is competition for every health care dollar out there from all the competing interests.

Talking about programs that we haven't even looked at, sexual trauma treatment for the women in the VA, there's not one program that's really running on that right now. We don't have any staff trained.

So if you're going to talk about competition, it's got to be competition for quality and not competition for the dollars. If we build it, I think you're going to keep your veterans in there.

And you don't have to spend a lot of money to do this. If you doubled us, we'd go from one and one-half percent of the VA one percent budget to three-tenths of one percent of the budget. We could have twice the amount of money we have now. We could build some good treatment facilities that would accommodate these special needs of women.

We're just not addressing them at all. And there's no input, no computer system, no statistical system, no tracking system, and no one that you could pick up the phone and call over at the Department of Veterans Affairs and say "Who's in charge and listening to us? If we have the statistics to give you, who would we tell it to?" There's no one over there to tell it to.

Mr. GUTIERREZ. Thank you very much, Mr. Chairman.

Mr. EVANS. Thank you for your testimony, and I thank everybody who has testified today. The testimony was very good. There are many witnesses who have worn the uniform of our country. Thank you for your past service and your continuing service to our Nation.

With that, we'll conclude the hearing.

[Whereupon, at 11:33 a.m., the subcommittee was adjourned.]

APPENDIX

Prepared Statement of Congressman Ridge

Thank you Mr. Chairman. Being that this is the first hearing the Subcommittee has held this year, I would first like to say that as the newly appointed Ranking Minority Member, I am looking forward to serving with you in this Congress. This year's agenda covers topics that are not only a personal concern of mine, but a concern of all those that are active in the Veterans' community.

Having served in Vietnam and having seen first hand the problems facing the returning veteran, I am pleased that you have scheduled today's hearing. This hearing will examine, among other issues, the health care services provided to Vietnam Era veterans, economic status and opportunities of these veterans and the need for and delivery of social services to both them and their family members.

The problems surrounding the Vietnam veteran today are the same problems faced by many Americans: lack of health care, a bad economy, and emotional and family problems. However, for a number of Vietnam veterans these problems are compounded by unresolved conflicts that are a result of them fighting for their country.

The recent headlines regarding President Clinton visiting the Vietnam Memorial on Memorial Day is just another indication of the wounds that still exist in this country regarding the Vietnam War. The continuing controversy surrounding the war does not make it easy for the Vietnam veteran to reintegrate into society. This is partly the reason that veterans make up over 30 percent of the homeless population nationwide.

Mr. Chairman, I again commend you for holding today's hearing. I look forward to hearing the testimony of today's witnesses and hope they can give us feedback on what this Committee is currently doing to alleviate some of the hardships facing the Vietnam Era veteran and where improvements could and should be made.

TESTIMONY SUBMITTED BY

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For Presentation Before

Subcommittee on Oversight & Investigations
House Committee on Veterans Affairs

May 5, 1993

As the number of female Veterans increases to nearly 10% of our Veteran population the specific programs that address their unique health care needs become a priority. Most women Veterans now receive no treatment or receive care in private hospitals. For example, mammograms requested by the Surgical Oncology service at the John L. McClellan Memorial Veterans Medical Center at Little Rock were done at the University Hospital until February 1, 1993. This often caused a delay in the treatment of the female Veteran and was a significant expense to the VAMC. In addition, mammographic abnormalities that required needle localization involved the transport of patients back to the VA with needles still in place in the breast. The population base to be served in the Arkansas area in 1991 was 10,606 Veterans in the State of Arkansas and 163,164 patients in the surrounding southern states including Louisiana, Mississippi, Oklahoma, Tennessee and Texas. Further, 2,002 more female beneficiaries from the Champ VA program which includes families of 100% service connected Veterans are in the State of Arkansas. The VAMC's in these southern states do not have mammography units nor did they have the expertise and equipment to deal with gynecological, urological or other medical problems unique to women. These data clearly indicated an unmet need. In these states there are 27 VA's, none of which had mammography. Because of lack of funding VA's in not only this region but the entire country are not in compliance with mandate G-5, M-2 and Circular 10-91-101 which are being submitted for exhibit material. The current accessibility to medical care for women at the VAMC is not unlike that for men. The problem lies in the lack of empathy for issues specific to women Veterans. Mandate G-5, M-2 issued on October 7, 1991, as well as Circular 10-91-101 issued on September 12, 1991, are directives that clearly outline services that are not being provided to our women Veterans. Women's clinics in VA's throughout the country do not meet the criteria for the mandate of G-5, M-2 since privacy and special needs for women are still at issue. Most are unable to comply with Circular 10-91-101 since they do not have mammography capability. To my knowledge only 23 VA's in the United States have mammography capability. Screening of the male and female veteran population is mandated for primary, secondary and comprehensive cancer centers, but not fully implemented. Unquestionably, screening will decrease long term cancer care costs.

The VA has taken significant steps on all levels - local, regional and central. A cost effective approach would be regionalization of specialized care i.e., establish centers of excellence. Two years ago we proposed a regional referral center concept for women's needs in the VAMC. Requests for proposals for four such centers will be funded at $750,000.00 for each center. This is a step in the right direction, but falls far short of the funding needed to take care of the enormous population that we are seeing since Vietnam and Desert Storm.

The women's initiative will provide an impact not only locally but nationally. Resources have not allowed us to properly address the health care needs of our women Veterans. Funding for women's initiatives will allow the VAMC to diagnose and treat the malignant and non-malignant diseases unique to women. In addition, we can fully institute screening and preventative health care programs which are known to be cost effective. Regional referral centers with limited funding can be prototypes for similar centers throughout the nation. Residency programs that rely upon the hospitals for their major training will be an added dimension to their VA experience. One of the prime directives to the VA is for residency training. To this point the VA has been a major training area for medical experiences and surgical experiences such as my own. Yet we're training on all males because of the lack of facilities for women. This initiative will broaden the experience for our training and keep the quality of medical care in this country at the current height. Without the VA experience most residency programs would fall short of the "excellent" mark.

Another prime directive to the VA mission is research. Not only does research permit the recruitment of high caliber physicians, but it also creates an intellectual environment that makes everyone perform at their best. Physicians, nurses, therapists, social workers all work better in a teaching and research environment. It is clear from the present budget figures that VA research will not be allowed to have any new initiatives in the year FY-1994. It should be made clear that cutting VA research funding will not save money for the VA but will increase the cost of health care. Research carried out within the VA system has saved both the VA and the nation billions of dollars because research findings have resulted in better health care and also more cost effective care. VA research has played an important role in bringing down the cost of medical care while increasing the quality of care available to our Veterans. Funding of VA research is an excellent business investment. Congress should not be remiss in supporting VA research. In addition, it is clear from available studies, for example in the area of breast disease, that too many research programs are going unfunded or lack sufficient numbers of patients to answer important questions. This point is further highlighted by our own southern region where there is no epidemiology data to indicate whether women Veterans in this area have increased cancer deaths. Some small studies have suggested that women's cancers are increased in the Veteran population. These and other questions cannot be answered until there is sufficient funding in VA budget for research. In the large cohort of women available through the VAMC you can implement studies on such important issues as Agent Orange, hormone replacement, preventative medicine, cancer screening, treatment and epidemiology. For example, at present nearly 80% of mammographic abnormalities are benign. Support for research and development of stereotactic devices would prevent needless surgeries at significant cost savings to the VAMC. Another example is simple estrogen replacement. Does

it increase the risk of breast cancer? Most studies carried out at present lack a significant number of patients. These questions could be answered within the VA system.

To Summarize: Not only are programs needed to address the unique health care needs of women, but also support for this care and research in women Veterans must be provided. These efforts are important to maintain and advance health care, research and medical training in this country. We are speaking today of women Veteran's issues, but I assure you that by supporting these issues for women Veterans you are directly improving the level of care given to <u>all</u> Veterans. This should not be a policy of exclusion, but inclusion.

WOMEN VETERANS COORDINATORS PROGRAM GUIDE

1. PURPOSE OF PROGRAM

The purpose of the WVC (Women Veterans Coordinator) is to oversee the women veterans program. Each VHA (Veterans Health Administration) facility will have a WVC to:

a. Assess the needs of women veterans, planning, organizing, and coordinate facility services and programs to meet identified needs; and

b. Make recommendations to the facility Director to ensure compliance with all existing VA policies and regulations.

2. BACKGROUND

a. The VA (Department of Veterans Affairs) Advisory Committee on Women Veterans was mandated by Public Law 98-160, dated November 1983. The Advisory Committee recommended to the Chief Medical Director the establishment of a WVC position at each medical center to ensure women veterans have equal access to VA facilities and receive high quality, comprehensive medical care. VHA Manual M-2, part I, chapter 29, sets the policy requiring each VA facility to appoint a WVC to serve as an advocate for women veterans.

b. VA Central Office has appointed a national coordinator for the Womens Veteran Program who is available as a consultant to WVCs and to the VA Advisory Committee on Women Veterans.

c. VHA facilities have been given the responsibility to establish women veterans programs and guidelines for operations. Since each facility has unique situations, patient population, staffing and patient needs, programs vary accordingly. This program guide suggests further guidelines to assist administrators and coordinators in developing and implementing their programs for women veterans.

3. SELECTION OF WVC

a. Each WVC will have:

(1) Knowledge about women's health care and aware of VA benefits and programs.

(2) Empathy for and knowledge of issues specific to women veterans is essential.

(3) Teaching ability and the willingness to speak in public to VA employees and community groups.

(4) Interpersonal skills and the ability to work independently as well as good communication skills, both verbal and written.

(5) An ability to interact effectively with all levels of personnel in the private and public sectors.

b. Each facility will select a WVC who can fulfill these requirements and the duties as discussed in the following paragraphs. There are no national or regional requirements that the WVC be a veteran or have a particular educational background.

4. MISSION OF THE WVC

a. The mission of the WVC will be:

(1) To inform the veteran of the presence of a WVC in the facility and to assure the veteran that the WVC's services are available.

(2) To assure that health needs of veterans, particularly as they apply to women, are being met.

(3) The WVC acts as a patient advocate for women veteran inpatients and outpatients.

(4) Acts as a consultant and ombudsman on issues pertaining to women veterans health care.

b. Suggested duties of the WVC include the following:

(1) Case Coordination

(a) Interviews women inpatients and provides information and assistance as needed.

(b) Orients women patients to the facility and to veteran benefits.

(c) Serves as consultant to the health care team to provide better understanding of the special needs and concerns of women veterans.

(d) Brings the concerns and unmet needs of women veterans to the attention of the facility director.

(2) Program Coordination

(a) Assures the compliance of the Women Veterans Program with all existing VA policies and regulations, facility procedures and policies, and other relevant requirements.

(b) Assists with planning activities, therapies, and building modifications which reflect the needs of women veterans.

(c) Develops a file of resources for women in the facilities and the community.

(d) Coordinates women veterans activities and programs within the facility.

(e) Presents information for and about women veterans in the community.

(f) Serves as liaison for women veterans with the administration of the facility and veterans organizations.

(g) Develops and maintains effective working relationships with women veterans organizations and auxiliaries.

(h) Collaborates with community agencies to develop and implement programs and activities for women veterans.

(i) Serves on appropriate community boards and committees.

c. Program Evaluation

(1) Monitors the availability of:

(a) Adequate hospital rooms (bedrooms, bathrooms, and exam rooms) with appropriate maintenance of privacy.

(b) Clothing (women's pajamas and robes) and personal needs (hair dryers, toiletries etc.)

(c) Canteen products specific to the needs of women patients such as lingerie, hair and skin products, and cosmetics.

(2) Evaluates women patients' satisfaction with care received.

(3) Works closely with the facility's Quality Assurance Coordinator in developing criteria for monitoring adequacy of health care for women veterans.

(4) Assists the health care team in meeting the established standards of care for women patients by reviewing medical records and notifying the responsible physician of areas not yet satisfied.

(5) Communicates results of quality assurance efforts related to women veterans to facility administration.

(6) Maintains statistics on women veteran patients and prepares reports in compliance with VA Central Office, Regional, and facility requirements.

5. TIME ALLOTMENT

WVCs should be allowed sufficient time to perform their duties. A flexible time allotment allows additional time for planning special programs and activities, handling complicated patient complaints, etc. Irregular hours may be necessary.

6. WOMEN VETERANS ADVISORY COMMITTEES

Women Veteran Advisory Committees assist WVCs in the performance of their duties with multidisciplinary team representatives.

7. REPORTING REQUIREMENTS

The WVC reports directly to the administration of the facility with regularly scheduled meetings at least quarterly. This direct line of communication permits a freer exchange of information. Reporting might address unresolved problems, unmet needs, and barriers to health care delivery to women patients.

8. ENVIRONMENT AND PHYSICAL SPACE

VHA facility administrations are informed by the WVC of the existence of physical barriers and equipment/supply inadequacies which impact on the provision of appropriate medical care to women or which cause discomfort during care episodes. Examples would be lack of privacy during examinations, inadequate bathroom facilities, failure to supply personal hygiene items, appropriately fitting pajamas, or expressions of a nonsupportive nature toward women patients. These barriers, inadequacies and attitudes will be corrected to the best of the facility's ability and in a timely manner. In the event a facility is unable to provide necessary services to women patients, referral to another VA facility or private institution will be made.

9. MEDICAL SERVICES

Inpatient and outpatient treatment for eligible women veterans will be provided in accordance with M-2, part I, chapter 29. Each women patient will have access to gynecological service, and will be offered pelvic and breast examinations. In addition, each medical center will have a written plan for the care of women veterans under its jurisdiction. The plan could be prepared by a task force or the WVC.

10. PRIVACY NEEDS

The consideration of the privacy needs of women veterans cannot be over-emphasized. Each woman outpatient and inpatient will be assured private examination areas, private rooms or sharing of rooms with other women patients, and privacy in bathroom and shower areas. In older facility buildings where private bathrooms and/or bathing areas are not available, every effort will be made to provide privacy though the use of signage or other means of designating occupancy by women patients.

11. QUALITY ASSURANCE PROGRAMS

a. Internal Review

(1) The comprehensiveness of services provided to women veterans is evaluated regularly and reported to the Chief of Staff. Concurrent monitors can be developed to assure that adequate care, as described in M-2, part I, chapter 29, is provided to women patients. Both inpatient and outpatient medical records will be monitored for:

(a) Completeness for history and physical examination for presenting problem.

(b) History and physical examination of inpatients including pelvic and breast examinations or reason for deferral and as a complete gynecologic history.

(c) Referrals for gynecologic services and mammography, especially those women who receive primary health care services from VA.

(d) Provision of patient education, documented consistent with the health care needs of each patient. Medical centers define, for quality assurance purposes, what is considered "timely" provision of routine gynecologic services, especially for those medical centers not having women's clinics.

(e) The effectiveness of the Women Veterans Program to ascertain if it is achieving its purpose, if it is practiced in the most efficient manner and if it has had an impact on the delivery of care to women patients.

(f) VA SCEM (Standards, Criteria, Evaluative Algorithm and Measuring Instrument) is available for self-assessment. Internal review may not always be the specific responsibility of the WVC.

b. External Review

The JCAHO (Joint Commission on Accreditation of Healthcare Organizations) standards do not differentiate between male and female patients. However, JCAHO surveyors look at all programs that impact on patient care. Therefore, programs for women veterans are scrutinized. It is important that documentation of medical care provided to women patients be accurate and timely. Mechanisms for monitoring of care and for the pursuit of continuous improvement is included in JCAHO, Veterans Service Organization, Inspector General and other surveys.

12. STATISTICS

WVCs can receive daily listings of women veteran inpatients from Medical Administration Service to facilitate the assessment of needs. WVCs may choose to maintain statistics on women inpatient admissions, women outpatient visits, and women's clinic enrollment.

13. REPORTS

WVCs are expected to comply with requests for information and formal reports from Central Office, the Regional Director's Office and local facility administration.

14. CONTINUING EDUCATION OF WVCS

WVCs maintain current knowledge of women's health issues, veterans' benefits, and referral resources by attending continuing education programs, inservice training, or by annual review of these areas. Orientation to the role of WVC is provided by the facility and/or the Regional WVC. Facility administration will assist WVCs in learning the program management skills necessary for completion of duties through local training and the support of the WVC's attendance at national and regional training conferences.

15. STAFF INSERVICE TRAINING

WVCs work closely with the facility's education staff to ensure the inclusion of women's health issues in the scheduling of inservice training programs so that staff are adequately prepared to deal with the health care needs of women patients and are aware of referral resources both within VA and in the community. All facility employees should receive orientation to the Women Veterans Program.

16. PATIENT EDUCATION

WVCs can be a consultant to the facility Patient Education Committee and can recommend topics such as self-breast examination, osteoporosis, eating disorders, gynecologic problems, menopause, and hormone replacement therapy. The WVC can facilitate utilization of the expertise of facility staff in providing education to women patients. Some teaching needs can be met by referral to the women's clinic, gynecology services, etc. Equitable allocation of resources can support the purchase of related patient education materials, to include audiovisuals, pamphlets and teaching models.

APPENDIX 11

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

TO:	11 cm		
ACTION	COPIES		
	520	114	

CIRCULAR 10-91-191

September 12, 1991

TO: Regional Directors; Directors, VA Medical Center Activities, Domiciliary, Outpatient Clinics, and Regional Offices with Outpatient Clinics

SUBJ: Screening for Breast Disease

1. PURPOSE: The purpose of this VHA (Veterans Health Administration) circular is to establish the policy on breast screening in VA (Department of Veterans Affairs) health care facilities. This circular will not be included in a manual.

2. BACKGROUND: Mammography is an established radiologic examination for detecting diseases of the breast. Diagnostic mammography for symptomatic women referred by the physician to a radiologist is generally available in the VA system through in-house and/or purchased services. Screening mammography of asymptomatic women reduces the morbidity and mortality of breast cancer by earlier detection at a more curable stage. Mammography screening has been endorsed by American Cancer Society, American College of Radiology, National Cancer Institute, and American College of Surgeons and is widely available in the community. These organizations have established criteria for screening and quality standards. The criteria for screening are included in Attachment A. Guidelines for mammography are included in Attachment B.

3. POLICY: Diagnostic and screening mammography will be available to eligible veterans through in-house and/or purchased services.

4. ACTION: Each VA medical facility will have a written plan for the provision of breast screening services which will include physical examination, education and mammography. Plans will address:

a. Periodic examination.

b. Patient education.

c. Diagnostic mammography.

d. Screening mammography.

e. Follow-up for positive/negative results.

f. Quality control for all aspects of the program.

The plan will be submitted to the Women Veteran Program Office (116C) 6 months from the date of this circular.

5. REFERENCES

a. American College of Radiology Mammography Resource Kit: Available through American College of Radiology, 1891 Preston White Drive, Reston, Virginia 22091 (703) 648-8900.

b. American College of Radiology Policy Statements on Mammography, 1986-1991.

THIS CIRCULAR EXPIRES SEPTEMBER 14, 1992

c. Kaplan, A.S., Wollerton, M.A., Rachlin, J.A. Selecting a Screening Mammography Facility. American Family Physician 1988, October 38 (4): 143-7.

d. Nielsen, B., Miaskowski, C., McCoy, C., Rudisch, M. The Development Implementation of Standards of Care in a Breast Cancer Screening Program. Oncol Nursing Forum 1991, Jan/Feb; 18 (1): 67-72.

e. Bird, R.E., McLelland, R. How to Initiate and Operate a Low Cost Screen Mammography Center. Radiology 1986 Oct. 161 (1): 43-47.

6. RESCISSION: This circular expires September 14, 1992.

7. FOLLOW-UP RESPONSIBILITY: Chief, Women Veteran Program (116C).

John T. Farrar

JOHN T. FARRAR, M.D.
Deputy Chief Medical Director

Attachments

DISTRIBUTION: CO: E-mailed 9/13/91
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ATTACHMENT A

CIRCULAR 10-91-101
September 12, 1991

PUBLISHED BREAST SCREENING POLICIES

1. National Cancer Institute

a. Mammography should not be used to screen women under the age of 35.

b. Mammographic screening of women aged 35 to 39 should be limited to women with a personal history of breast cancer.

c. Annual mammography for women aged 40 to 49 is justified only for women who have a personal history of breast cancer or who have immediate relatives with a history of the disease.

d. Mammographic examination may continue to be offered annually to women over age 50.

2. American College of Radiology

a. For asymptomatic women, the first or baseline mammography should be obtained by age 40. An earlier age is preferable when there is a personal history of breast cancer or a history of premenopausal breast cancer in the patient's mother and/or sister.

b. Subsequent mammographic examinations should be performed at 1- to 2-year intervals determined by the combined analysis of physical and mammographic findings and other risk factors, unless medically indicated sooner.

c. Annual mammography and physical examination are recommended for all women over 50.

3. American Cancer Society

a. Monthly breast self-examination starting at age 20.

b. Physical examination of the breast at 3-year intervals between the ages of 20 and 40, and annually thereafter.

c. A baseline mammogram between the ages of 35 and 40.

d. Annual or biennial mammograms from 40 to 49.

e. Annual mammograms from 50 on.

MAMMOGRAPHY GUIDELINES

1. PURPOSE

These guidelines for the administration, performance, reporting, and follow-up of screening and diagnostic mammography are published for use in developing in-house and/or purchased mammography.

2. BACKGROUND

a. There is a recognized necessity for the development of mammography services designed to meet the needs of women veterans. The ACR (American College of Radiology) in conjunction with the ACS (American Cancer Society) has issued recommendations for the screening of women for breast cancer. They have used quantitative and quality issues related to mammography.

b. Diagnostic and screening mammography should be performed for eligible women veterans in a radiology facility by a certified radiologic technologist under the supervision of a qualified radiologist according to the screening selection guidelines of the ACR and ACS.

3. GUIDELINES FOR PERFORMANCE OF MAMMOGRAPHY -

a. The technologist performing the examination must be certified by the American Registry of Radiologic Technologists and have had special training in mammography.

b. Mammography shall be performed using only dedicated equipment.

c. An adequate quality assurance program shall be in place which examines equipment, film quality and developing criteria, etc.

d. If breast biopsies and/or surgery are to be performed at the VA medical facility, provisions must be made for diagnostic specimen radiography.

e. At the current time, a projected workload of 500 examinations per year appears to be the minimum necessary to maintain quality and cost-effectiveness for in-house mammography. This figure is constantly being re-evaluated and applications for new in-house workloads less than 300 per year will be considered for approval by the VACO Radiology Service on an individual basis.

4. GUIDELINES FOR REPORTING AND FOLLOW-UP OF MAMMOGRAMS

a. A mechanism must exist for assuring timely reporting of mammogram results to the patient, the referring physician and the patient's medical record.

b. The typewritten report is to be on the medical record preferably within 24 hours but no later than 1 week after the mammogram.

c. Mammographic reports of findings suspicious for cancer or requiring immediate follow-up should be communicated by the interpreting radiologist directly and immediately to the referring physician or a designated responsible person on the permanent VA hospital or clinic staff.

d. A mechanism must exist for guaranteeing prompt scheduling of patients with suspicious mammographic findings for further diagnostic tests, surgical consultation, or biopsy.

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STATEMENT OF

VIETNAM VETERANS OF AMERICA

Presented By

Linda S. Schwartz, RN, MSN.
Chair VVA Women's Veterans Committee
Chair VVA Legal Affairs Committee

Before The

House Veterans Affairs Subcommittee on Oversight and Investigations

On

Community Perspective on Health Care, Economic Opportunity and Social Services Available to Vietnam Era Veterans

May 5, 1993

INTRODUCTION

Mr. Chairman and members of the Committee, my name is Linda Schwartz. I am medically retired from the United States Air Force Nurse Corps and a Doctoral Candidate at Yale University School of Medicine, Department of Epidemiology and Public Health. I also have the honor to serve as the Chairman of Vietnam Veterans of America's Legal Affairs and Women Veterans Committees. I also serve as a Trustee of the Connecticut State Department of Veterans Affairs. I want to thank you for giving me an opportunity to discuss Vietnam era veterans perspectives on VA health care services, economic status and opportunities, and the need for and delivery of social services to veterans, their families and children.

THE FUTURE ROLE OF VA HEALTH CARE

Defining the role of the Department of Veterans Affairs will be one of the most important and challenging aspects of the work of the President's Task Force on Health Care Reform. The past history and present status of the VA illustrate what can happen to a large health care delivery system which is vulnerable to political pressure and public opinion. Regardless of the particular details of any programs adopted, the handwriting is on the wall. There must be emphasis on efficiency in delivery systems, cost effective utilization of allotted resources and quality health care as defined by the consumer.

Many veterans, including Vietnam veterans, see the VA as the only tangible sign of the government's regard or appreciation for their military service. These days, some veterans are given to an argument over the semantics as to the VA being an entitlement rather than a benefit or visa versa. I have used VA services for eight years. In the clinics and hallways of VA Medical Centers, I have watched veterans young and old endure the experience of being "lost" in the largest and most expensive care system in the world. I could not ignore what I saw. The politicization of illness and disability is neither a benefit nor an entitlement. Yet this is undeniably the essence of what a health care system managed by Congress has by it's very nature become.

Without question the issue of greatest importance in the veteran community is the future role of VA health care and the changes that will come as a result of the work of the Task Force on Health Care Reform. How will the VA sustain it's relevance amidst the sweeping plans to guarantee quality health care for all Americans? While many in the veteran community fear the changes that might result from Task Force recommendations, the process promises to be one of opportunity rather than crisis. It is important to remember that the VA does not operate in a vacuum. In states, counties, and cities all over America there are programs and services that are rarely factored into any discussion of assistance to veterans.

State Homes, County Outreach Centers, State subsidies to disabled veterans, widows and orphans, funding for education, private industry apprenticeships for veterans and countless dollars and hours of volunteering from veterans service organizations are all actively reinforcing the present federal programs. How many of these services are duplicated or overlap? Is there active communication between agencies? It would seem that the task is to assess the real extent of these local and private programs and services and to consolidate present resources in an effort to avoid duplication while ensuring that eligible veterans and their families receive a continuum of quality care.

We need to get real. Real numbers of eligible veterans and present users of VA facilities, their locations and the nature and

extent of their health care problems must be learned. We need to define the problems before we can begin to solve them. Reform means reassessing, realignment, repair, and reconstitution. Although past plans for a national health care program have rarely included provisions for changes in the VA, there is no doubt that any effort to truly change the system must include this largest agency in the nation. Justification for maintaining VHA will need to be based in reality not as a response to rhetoric.

The present missions assigned to VA need to be considered in the light of the changes we will see if we have the health care our President envisions for all Americans. The days of the VA attempting to be all things to all people must end. This posture for VA is unrealistic. In a new era of health care, the Congress will have to evaluate the need for the VA to continue to provide acute care services when the bulk of the veteran population is growing older and more in need of long term and chronic health care. The idea that the VA will be the only training ground for America's medical schools and researchers will also become a thing of the past as other sources emerge to provide more options for these missions.

One of the many lessons we learned in America's military mobilization for the Persian Gulf War was the importance of the VA as a backup for the Department of Defense. As a Retired Air Force Nurse, who cared for casualties during the Vietnam war, I seriously questioned if the VA had the resources to adequately handle the kinds and numbers of injuries that were originally projected to occur if the land war became protracted. Perhaps the interface with military health care systems will remain an essential part of the VA mission. It is important to remember that such a vital role needs to be supported with adequate funding, planning and training of personnel and that this auxiliary system be in a constant states of readiness. In a new era of health care, there is immense potential for an integrated federal health care system which would capitalize on the strengths of the US Public Health Service, Department of Defense and Department of Veterans Affairs to provide quality health care for active duty military members, eligible veterans and their families.

Regardless of what shape the future of health care in America takes on, there remains a great need to ensure that veterans who use the VA receive timely, courteous quality care. While the VA can demonstrate that per capita costs for care are less than care in the private sector, one has to question what we are talking about in regard to care? The VA needs to focus on quality as more than an outcome and more than utilization as the benchmark for measuring value in their delivery systems.

Quality care is in the eyes of the users. Veterans know where to go and who to see to get the best care. They travel miles in a bus across Texas to a substance abuse program because the nurse there really takes care of you if you are serious about your problem. They come from the backwoods of Maine and Vermont to West Haven to see two doctors there who really care. The opportunity of the future VA is to focus on the services VA does best. Post Traumatic Stress Disorder, Prosthetics, Spinal Cord Injuries, Homelessness, Seizures, Geriatrics are only a sample of the care VA does better than anyone. Other services can be arranged or complimented by developing a network of preferred providers, contracting reciprocal agreements with medical schools, increased utilization of Clinical Nurse Specialists, Nurse Practitioners, Physicians Assistants and Mobile Health Care Clinics.

While many may not think of Connecticut as being particularly rural, those veterans residing east of the Connecticut River are 65 miles or more from the nearest VA. Recently a group of veterans found that because of their disabilities, they were unable to make the long trip for outpatient care. They wrote letters to the editor of local papers asking if any other veterans in the area

were having the same problem. Last count, there were over 500 letters and in excess of 300 calls. One man, who lost both legs in World War II, told them he could never make the trip so he'd been paying for his own care from his disability check. We have begun to work with our Congressman Sam Gedjenson and the VA to see what can be done about this problem. The communication between the VA started with an Advisory Committee at the West Haven VA.

In the last 18 months, I have been to three VAMC's because of complaints from veterans about hospital administration policies and in two places about multiple Vietnam veteran suicides. Each time I have found that communication between these facilities and the veteran community was either one way or nonexistent. Basically the VA is a closed system, information flows one way, veterans are acted upon and have very little sense of ownership in the hospital or facility they frequent.

Because consumers of VA health care are not the purchasers of that care, the sense of accountability to the customer-consumer-veteran is very far away in a place called the Central Office. In each of the VAMC's I visited, I suggested that an Advisory Committee be formed to give veterans an opportunity to have input in the process, a forum to raise questions and defuse misinformation, as well as working with the hospital administration to improve conditions. As these committees have begun their work, there has been a reluctance in some places to share even this small amount of "power". However I am also happy to say in others like the West Haven VAMC, we have truly developed a partnership which has strengthened the consumer-provider relationship and promises to be a new resource for improved conditions at the hospital.

In Connecticut, we have developed a very efficient and complete program for homeless veterans. Originally the State Commissioner of Veterans Affairs convened a group of representatives from the VA Regional Office, State and Federal Departments of Labor, Educational Institutions, Drug and Alcohol Treatment facilities and VA Medical Centers. His charge to this group was to help him design a program which would help veterans with substance abuse problems recover, stabilize and transition back into the community successfully. As needs became evident, each member of the group stretched to make a contribution to help.

Agencies waived eligibility requirements for specialized needs of veterans with learning disabilities, vocational rehabilitation interns were recruited through State Universities and contracts with the local Community College brought EMT and Nurses Aide courses to the campus of the Veterans Home and Hospital. To date, over 300 homeless veterans have been helped by this program and more are in the process.

Last summer the West Haven VAMC was under seige for suicide deaths near and in the facility. Perhaps the legacy of those scandals is the strong ties we developed and the common sense attitude of state and federal officials to get the job done. The VAMC's and our VIP program at the State Hospital, as well as providers in the private sector, and Veteran Service Organizations now work together to ensure homeless and disabled veterans have a continuum of care that gets results. I believe this is a cost effective model for the future care of veterans.

HEALTH CARE QUALITY

The November 1992 House Committee on Government Operations report "Continuing Deficiencies in Department of Veterans Affairs Medical Quality Assurance Programs" identified several of the problem areas we have noted in previous testimony. Although it is usually reassuring to have one's suspicions confirmed, there is little consolation in learning how severe and widespread some of these quality of care issues are. Particularly disturbing were the

findings that physicians credentials are not adequately reviewed, there is a lack of informed consent and cancer patients were not being informed of their diagnosis. These deficiencies suggest that even the basic rudiments of adequate health care are denied to veterans.

The report also noted that incidents of inappropriate medical care are increasing at VAMC's as well as the fact that preventable errors may have caused unnecessary patient deaths. While some of these findings could also be noted in investigations of any hospital, practices within VHA do not indicate any effort to address these weaknesses.

The VA was also sited in the report for failing to adequately analyze and correct high mortality rates at its Medical Centers. The report further noted that the VA failed to adopt adequate measures to prevent avoidable malpractice at it's hospitals and that these problems had also been found by the GAO and VA's own internal quality assurance programs in 1987. Internal records at VA provided evidence that the Department does not analyze malpractice claims, nor does it take any action to improve adverse outcomes identified as malpractice.

When these problems were previously identified, the VA promised to look at malpractice cases to determine if there were discernible patterns of inappropriate care which would help to establish preventive procedures. While this process is standard for most hospitals, VA failed to follow up on the promised analysis.

It is more disconcerting to realize that these problems continue to exist in a system so vast. I am reminded that the criticism of government in health care is often portrayed as being an attitude of "it's OK for veterans because we need them for research and as learning experiences for our interns and residents but not on my family or for me". At one of my first classes at Yale the professor told the class "If you want to do research, do it at the VA, the veterans are so docile and willing and they can't sue you." I became so enraged at the suggestion that I think that was the day I decided to become a voice for veterans. How is it that there is no improvement of follow up on these investigations and veterans are left to fend for themselves in a system that does not demonstrate an aggressive effort to correct deficiencies? The answer is as plain as my professor's estimation "they can't sue you".

However, budgetary constraints have also struck at the very heart of the VA health care system. VAMC's report low nurse to patient ratios. In some cases VA nurses have twice the patient caseload of their peers in the private sector. Lack of support services also means that nurses and other VA professionals "on the front lines" have to do more with less. While their commitment is impressive, the lack of support turns many excellent competent and caring clinical providers away from the VA system. It is important that budgetary positions keep pace with the demands made on these professionals by the increasing severity and complexity of patient needs.

AGENT ORANGE

In February, I spoke to the National Academy of Science Committee studying the effects of herbicides on Vietnam veterans. This Committee is tasked with identifying diseases that have a significant statistical relationship to exposure to Agent Orange which would merit compensation by the VA. My report was based on an additional analysis of the National Vietnam Veterans Readjustment Study (NVVRS) of the physical health problems of women who served in Vietnam.

Although no one can foresee what the final report which is due

out this summer will say, I was troubled to hear these scientists tell me they had been told women were not exposed to herbicides in Vietnam so they had not given them much thought. It seems so incongruent to think that once again women could be so easily dismissed. I believe my presentation broadened their perspective on the experiences and potential exposure of women who served in Vietnam. Of particular importance were the findings that women Vietnam veterans had significantly higher rates of negative reproductive outcomes, higher rates of tuberculosis and multiple sclerosis than era and civilian women. Unfortunately we will not see the 1986 Congressionally mandated study of the Health Status of Women Vietnam Veterans because of delays and fragmentation of the original concept.

The tragedy of this problem is the years and years of debate while a new generation--children of Vietnam veterans--exhibit symptoms and defects which could be attributed to their parents' military service. So many unanswered questions lay like a heavy stone on the hearts of these parents. Not long ago a women called me from Indiana, wanting to know if there were any Agent Orange studies on women. She told me she'd had 13 miscarriages and a hydatiform mole which she called a baby. She had three children, two with birth defects. She had cancer of the stomach and thyroid, mitral valve prolapse with repair, Non Hodgkins Lymphoma, and recently had a cancerous growth removed from her leg. She wondered if any of this had anything to do with her service at Pleiku in 1967-68.

I wish I could have given her a better answer than we have available. I think she deserves some kind of answers; she and all the mothers who had babies born with cancer, or lost babies in miscarriages; mothers who have children slow to walk and learn; mothers who volunteered to serve their country and now believe their children pay the price for that decision.

These many years after the war, we struggle with the thought that the taint of herbicides has seeped to our children and the unborn. For some veterans, the cost of medication for their children is hundreds of dollars a month. In some cases almost half their disability check goes for family health care of the problems they attribute to exposure to Agent Orange. If for no other reason than to lay to rest these questions, there is a need to establish a National Children's Registry for children of Vietnam and Persian Gulf veterans to determine any trends and the extent of these problems. It is time we used the science we have to answer as best we can these questions rather than as a method to dishearten these families even more.

POST TRAUMATIC STRESS DISORDER

As we have learned more about the nature of PTSD, there is a need to consider once again expanding the mission of Readjustment Counseling Services (RCS) Outreach Centers to include veterans of WWII and Korea. In FY 1990 these veterans accounted for 17.8% of the new cases seen in Vet Centers. It is evident that the success of VA in treating Vietnam and post Vietnam war veterans has given older veterans hope that they can get help for their symptoms and troubling memories. Because the VA has attained a reputation through the National Center for PTSD as being the experts in the field of PTSD, it seems appropriate to allow any wartime veteran in need to have access to this specialized care.

In the discussions about the present status of PTSD care and the extent of need for additional resources, it is important to consider that references to the NVVRS is somewhat old news in today's world. Because the NVVRS is a rich data set which lends itself to revisiting a sample of the veterans previously studied, Congress should explore the possibility of allocating funds for a longitudinal study of a portion of the veterans surveyed in the

original study. This would be a very cost effective resource for the care of veterans with PTSD.

The Advisory Committee on the Readjustment of Vietnam and other War veterans has been both active and helpful in assisting VA in it's appraisals of needs of wartime veterans. Although President Clinton has mandated that a large portion of existing Advisory Committees should be terminated, it is imperative that this particular group be codified to protect it's very valuable role and contributions to VA services and wartime veterans.

WOMEN VETERANS HEALTH CARE

Section I of the Veterans Health Care Act of 1992 was a landmark victory in the long struggle by women veterans to assure continued recognition and support for their specific health care needs. VVA is proud of the leadership role we have taken in the last ten years to spearhead these efforts. However, the legislation which calls for the development of well women health care programs, broadening the context of service connected Post Traumatic Stress Disorder to include the aftermath of sexual trauma and authorization of funding for a Women Veteran's Health Study are only initial steps in adequately addressing the needs expressed by women eligible for VA health care.

We have noted, at hearings in the Congress, in the media and within our own membership, that women veterans consistently voice the same problems, year after year, with no real hard evidence of a concerted effort at the VA to address these issues. More often than not, complaints or reports of inadequacies in the system are treated as if they were anecdotal rather than the symptoms of systemwide deficiencies. Increased numbers of women serving in the Armed Forces will and are becoming eligible for VA programs. If we are to really address the needs of these veterans, there has to be a more conscious effort on the part of the VA to assure that women receive quality care.

With the new authorizations for health care programs, funding for women veterans coordinators and research for women veterans, there is need for more accountability than can be assured by the present staff and their access to the Secretary. VVA suggests that the time is appropriate to establish a more formalized process to assist women Veterans by developing a department within the VA much like the Department of Labor's Women's Bureau. We believe the recurring problems of outreach, privacy, adequate physicals and any other gender related issues would be best addressed if there was some structured oversight within the VA.

Not only could this Department serve as a clearing house for present programs designed specifically for women veterans, there is the additional potential for program evaluation and planning based on research and hard facts instead of relying on the traditional tools of rhetoric and conjecture. The establishment of a structural unit dedicated to women would reflect the Department's interest and commitment to rectifying the mistakes of the past and it's resolve to maintain the standard of care these veterans deserve. More importantly it would be a major step in instituting a method to assure the maximum utilization of resources designated to assist women veterans.

ADJUDICATION OF CLAIMS

It is estimated that each year 4.5 million claims are processed by the VA. This system is not user friendly. There are serious systematic problems which are a cause for concern. Decisions by the Court of Veterans Appeals confirm that an inherent adversarial relationship has developed between adjudicators in VA

and the veterans they are required to serve. Often VA, DOD and Regional Offices seem to ignore each other and veterans. Additionally Veterans Benefit Administration managers are evaluated on quantity not quality or resolution of cases. This system engenders a revolving door scenario where one claim inadequately developed by VA can be channelled back and forth through a series of desks for years while veterans and their families await a decision on their disability and relief for the difficulties they endure.

Traveling BVA Boards are probably the most cost effective and convenient part of the process for veterans. However, because of the limited availability and scheduling policies, some veterans are now waiting two years for these Boards because they are not able to travel to Washington. Thought should be given to increasing funding to these Traveling Boards to allow more time for cases to be heard at the local level.

VETERANS PREFERENCE

The Veterans Preference Act of 1944 was a mainstay in the successful transition of World War II and Korean War veterans. Today's hard economic times make circumstances unusually harsh for veterans. Presently, for example, veterans make up 11-13% of the overall work force, yet they are 21-26% of all dislocated workers laid off by plant closures and declines in industry.

Some of these veterans have relied on the promise of Veterans Preference to provide a federal employment advantage to them just as it had helped their fathers in times past. Sadly this is not the case. More often than not, Veterans Preference is a cruel joke which presents yet another frustration for veterans in need.

I am well aware that feminists and minority interest groups are bitterly opposed to any veterans preference in employment opportunities. However, I would suggest that the present composition of the active duty force reflects higher percentages of women and minorities than in the past. Veterans status is no longer uniquely male or caucasian.

As we begin to downsize the Armed Forces there are estimates of 1.3 million military members being released from the service. Because these individuals were not drafted, it is fair to assume that they joined the military for a career. It has been estimated that women will suffer the greatest impact of this reduction in force. Also of interest, the 1985 Lou Harris Study of female veterans found that employment was one of the greatest problems for women veterans of the Vietnam and Post Vietnam era. At face value there are a variety of military occupational skills that do not translate into any civilian employment opportunities.

Often one factor which gets lost in any discussions is the fact that there is a great deal of sacrifice when one volunteers to serve in the military. Because the concept of Veterans Preference is still set aside to assist these individuals, it is important that Congress strengthen the language of the present law to insure veterans now and in the future receive special consideration in the workplace. It is especially important that agencies like the Postal Service and the Tennessee Valley Authority be required to set an example by fairly implementing this program.

SERVICE TO FAMILIES AND CHILDREN

Among the many facets of the NVVRS was data on potential malfunctions in marital and family roles. This assessment included conventional measures of marital status and history, marital and relationship problems, parental role dissatisfaction or problems and family adaptability and cohesion. Findings of the study only confirmed the problems we have witnessed over the years.

The study concluded that levels of war zone stress significantly correlated with numbers of divorces and poorer family relationships. We have learned that PTSD does not only affect the veteran but impacts on family situations and functioning. Balancing the needs of all family members is one of the greatest challenges of living with a war survivor with PTSD.

Effects of any disability on children and spouses of veterans are both far reaching and complex. Disruption and instability of family environments extract a heavy toll on spouses and children of veterans.

The NVVRS found that spouses of Vietnam theater veterans were less happy and satisfied, had more marital problems, family violence and substance abuse than era veterans and civilian spouses. A significant number also report that they had experienced nervous breakdowns. The study also found that children of male Vietnam veterans with PTSD had more behavioral problems that were severe enough to be clinically significant than other children in the study.

In addition to the emotional upheaval there is the problem of health care for these families. Because veterans who are 100% disabled for PTSD are rarely determined as being "Permanent and Total", their families are ineligible for many VA services they actually need. Although the veteran is unable to earn a living and support the family, the family suffers because of present barriers to assistance for them if the veteran was rated "Permanent and Total". While services to families and children are not mandated, it is clear that it is impossible to treat a veteran in a vacuum.

Stress on families and support systems is stress on the veteran. The spouse and children are an integral part of veterans successful treatment for disabilities, be they physical or psychological. Service to a veteran must be based on need not policy. No one who could benefit from a waiver of regulation should be denied the assistance, services and programs needed if they are available.

Mr. Chairman this concludes our testimony.

U.S. House of Representatives
Committee on Veterans Affairs
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Aldo O. Rodriguez
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TO: The Honorable Lane Evans, Chairman
Subcommittee on Oversight and Investigations
and
Honorable Members
U.S. House of Representatives Committee on Veterans Affairs:

FROM: Aldo O. Rodriguez representing
New England Gay, Lesbian, & Bisexual Veterans of Boston

RE: Health Care Concerns of Minority Vietnam Era Veterans

DATE: 5 May 1993

I am here today to testify on behalf of minority Vietnam Era Veterans and their concerns. These minority veterans are black, hispanic, asian, American indian, homeless, gay, lesbian, and bisexual.

I am a gay minority veteran and an active member of the New England Gay, Lesbian, & Bisexual Veterans of Boston. I served in the United States Army in 1977 and was honorably discharged. I hold an Associate in Science degree in Nutrition/Institutional Foodservice Management. I currently work for the Department of Veterans Affairs Outpatient Clinic in Boston as a Medical/Eligibility Clerk. On a daily basis I am confronted with minority veterans and their concerns.

Studies indicate that about one-third or more of the adult homeless population in the United States served in the armed forces. An estimated 150,000 to 250,000 veterans are homeless on any given night, with perhaps twice as many experiencing homelessness at some point during the year. Many other veterans are considered " near homeless " or " at risk " because they are poor, suffer from various infirmities, have no home of their own, and live on a temporary basis with friends or relatives. A disproportionate amount of the homeless veterans coming for treatment to the VA Outpatient Clinic in Boston are black. Most of these black veterans are not your typical alcoholic or drug addict that has lost his or her home because of negligence due to substance abuse. These black veterans 9 times out of 10 are homeless as a result of physical or mental wounds like P.T.S.D.-Post Traumatic Stress Disorder caused by combat service in Nam. And, lack of treatment for this condition as a result of lack of knowledge of VA care available to treat such condition is the result of the veterans homelessness. I find that many of the veterans are not even aware of their entitled benefits and the many different types of treatment clinics available.

With respect to hispanic veterans, I find that their biggest concern is the existing language barrier. This language barrier often results in poor communication with patient and doctor which then causes poor medical care and treatment. Often, hispanic veterans coming for care at my facility speak very little English if any at all. Many come to the clinic for compensation exams and routine care. At the clinic, there are very few if any professional bilingual medical staff. I find myself running around from floor to floor acting as a translator for medical staff rather than doing my own assigned work in my own department at the clinic. There is no one else available to act as translator. Recently, I spoke to Mr. Jorge Mendoza. He

is a hispanic social worker at the New England Shelter for Homeless Veterans in Boston. Jorge Mendoza told me that one of the biggest problems he finds constantly confronting hispanic veterans is the language barrier. He remembers once sending a hispanic veteran that was homeless and suffering from substance abuse to the VA Outpatient Clinic in Boston for treatment. The veteran was given the run around at the clinic. The veteran, Mr. Gilberto Martinez, told Jorge Mendoza that no one formally communicated with him. They didn't even try to understand him or get a hold of an interpreter to help with translation. He was basically ignored and rejected. Mr. Jorge Mendoza then refered Mr. Gilberto Martinez to a Spanish organization called " Casa Esperanza "-(House of Hope). Casa Esperanza is a long-term treatment center for drug and alcohol substance abuse. Your stay at this facility can range anywhere from 6-months to 1-year maybe longer. Casa Esperanza did not reject Mr. Gilberto Martinez. The organization's counselors went out of their way to help Mr. Martinez. Mr. Gilberto Martinez was able to straighten out his life as a result of the patience, devotion, and dedication of the many counselors at Casa Esperanza. He has been sober now for almost 2-years. Jorge Mendoza told me, " It's strange Aldo, when the United States Military drafted Mr. Gilberto Martinez during the Vietnam War, they couldn't care less that he knew little or no English. Today in exchange for some medical care, they want Mr. Martinez to recite the entire Encyclopedia Britanica in perfect English. " Jorge Mendoza went on to say, " some people say to me that the hispanic veteran should learn the English language. But, I tell them that it isn't that easy for an older person to learn a new language especially a person with physical and mental problems caused by combat service." From my experience at the Boston clinic, I find that the language barrier problem is not exclusive to hispanic veterans. Many asian veterans seeking treatment at the Outpatient-Clinic are confronted with the same problem of language.

Every television program focusing on the subject of drug and alcohol abuse in America always mention the fact of an epidemic of drug and alcohol use and abuse in the black, hispanic, and American indian communities. However, almost 99% of the veterans I see receiving treatment for drug and alcohol abuse at the Boston VA Outpatient Clinic's Methadone-Unit are white male Vietnam Era Veterans. You can count the black, hispanic, and American indian veterans enrolled in the Methadone-Unit with one hand. This I believe is a direct result of little or lack of community outreach to minority veterans. Once again, I find that many of the veterans are not aware of their entitled benefits and the many different types of treatment clinics available.

Because of the 50-year ban officially excluding gay men, lesbians, and bisexuals from military service, gays are the most apprehensive when seeking care or counseling at VA medical care facilities or Federal vet-centers. AIDS has taken its toll in the gay, lesbian, and bisexual veterans community. There are gay veterans that are infected with AIDS. Because of the double stigma of both being gay and infected with AIDS, many gay, lesbian, and bisexual veterans avoid medical care out of fear that they may end up receiving judgment rather than medical treatment. Many gay veterans confronted with AIDS fear that most counselors and other medical staff will not be sensitive to their special needs and concerns. This fear is probably reenforced by the fact that out of 195 Federal Vet-Centers not one has an official gay counselor on staff. This fact makes a gay, lesbian, or bisexual veteran believe that since they are not officially being recognized maybe they are not really welcome.

In order to address the needs and concerns of the minority veterans I have mentioned, the following are my recommendations to the committee:

1.- With the cooperation and assistance of community leaders, develope community outreach programs for minority veterans to educate and inform minority veterans on the many medical benefits and medical

care treatment facilities available to them upon leaving active duty.

2.- The Department of Veterans Affairs hiring more bilingual professional staff doctors, nurses, and clerks to work in its medical-care facilities to help non-english speaking veterans with translation when these veterans seek treatment.

3.- There are 195 Federal Outreach Vet Centers. Hire gay counselors at these facilities to address the unique concerns of the gay, lesbian, and bisexual veteran community.

4.- Support the Honorable President Bill Clinton in his efforts to lift the 50-year old ban on gay, lesbian, and bisexuals serving in the United States Military.

In conclusion, many minority veterans black, hispanic, asian, American indian, homeless, gay, lesbian, and bisexual have served with honor and distinction in Vietnam and other wars. Please recognize their needs and concerns. Thank you.

Sincerely,

Aldo O. Rodriguez

Aldo O. Rodriguez

Testimony

of

Jeff Tepsitch, MSW

HIV/AIDS Program Coordinator

Department of Veterans Affairs Medical Center

Boston, Massachusetts

Health Care, Economic Opportunities and Social Services, A Vietnam Era Veteran Community Perspective.

U.S House of Representatives

Committee on Veterans Affairs

Subcommittee on Oversight and Investigations

May 5, 1993

Mr. Chairman, Members of the Committee, thank you for inviting me to appear before the subcommittee today. I would like to take this opportunity to address two matters. First I will give a brief report on the HIV/AIDS program at the Department of Veterans Affairs Medical Center, Boston. Second, I would like to share with the Committee current and projected treatment needs.

The AIDS epidemic continues to escalate, claiming the lives of more people daily. As of March, 1993, 171,890 people in the United States have died from AIDS. An estimated 1.5 million people in the U.S are currently infected with the HIV virus. It is currently estimated that 1 out of every 100 men and 1 out of every 800 women in this country are infected with the HIV virus. The Department of Veterans Affairs has treated over 14,000 cases of AIDS as of December, 1992. In December, 1990, The Department of Veterans Affairs had treated 10,129 cases of AIDS. As of December 31, 1992, the Department of Veterans Affairs had treated 14,649 AIDS cases. This amounts to a 45% increase in a two year period.

The HIV/AIDS Program at the Department of Veterans Affairs, Boston provides a specialty clinic to help HIV infected veterans cope both medically and psychologically with this disease. Our clinic is staffed by the Infectious Disease Chief, his staff of ID physicians and fellows, a clinical Salk Vaccine trial nurse, a Ryan White Grant funded social worker, and myself.

Most veterans seeking care present at intake with a multitude of psychosocial problems. Many have active substance abuse problems, are homeless, lack an income, or are having difficulty coping with their HIV status. Many veterans find it difficult to seek care at a VA as they see themselves as unworthy, either because of their substance abuse history or the fact that they have previously denied their homosexuality. Many expect to be treated shabbily but recognize the need for care. It is crucial to help veterans feel welcome, provide supportive counseling, and help them obtain benefits to help stabilize their lives so that they are better able to cope with their HIV disease.

Social Workers help veterans apply for entitled benefits and locate affordable housing. Currently, there is a significant

shortage of safe affordable housing in the Boston area. Based upon my experience, veterans are not very compliant with keeping medical appointments for follow-up of their HIV disease when worried about where they are going to sleep that night or what they are going to eat. Social workers help veterans access substance abuse treatment as well as provide individual or group therapy to help veterans cope better psychologically.

One area of particular concern to me as a social worker is disability benefits once a veteran becomes disabled from AIDS. Veterans may apply for Social Security benefits or a non-service connected pension upon obtaining an AIDS diagnosis. In order to apply for a non-service connected pension, the veteran must have served for at least 90 days during a time of war. I feel that the Social Security Administration and the Department of Veterans Affairs are doing an excellent job at determining when someone is truly disabled from AIDS and can no longer realistically be expected to maintain gainful employment but it is the reality of how these decisions effect a persons ability to obtain medical insurance that concerns me. For example, if a 40 year old man who has worked the majority of his adult life is diagnosed with AIDS and can no longer work as a consequence of the disease, applies for Social Security Disability benefits, he will certainly be awarded a monthly income based upon the number of quarters he has worked as well as the salary he obtained when able to work. The Social Security Administration will then calculate the amount of his monthly check to which he is entitled. This 40 year old will not be entitled to Medicare until he has been receiving his Social Security Check for two years. This sends a conflicting message. On the one hand, the message is that you are disabled but on the other hand, not entitled to insurance for a period of two years. Currently, from the date of an AIDS diagnosis to death is approximately 2-3 years. When Social Security and Medicare were first implemented, they were designed to provide a form of supplemental income and medical insurance to the elderly and disabled. Back then, nobody envisioned AIDS and its consequences among so many of the young.

Veterans who served during a time of war and become disabled due to AIDS are entitled to apply for a non-service connected pension. Once determined eligible, they are awarded a monthly check in excess of what SSI would pay. Currently the monthly amount for a single veteran is $ 617.00 per month. In Massachusetts, the maximum allowable monthly income for a single person to be eligible for Medicaid is $580.00 per month. The awarding of a non-service connected pension therefore automatically makes one ineligible for Medicaid. In the early stages of AIDS, the lack of insurance is of little consequence to veterans as they may obtain their medical care at Department of Veterans Affairs Hospitals. As their disease progresses, veterans are faced with deciding where to die. Whether, in a VA hospital, an institution such as a residential AIDS hospice, or at home. Arranging for a veteran without insurance to be discharged to an AIDS hospice or die at home is extremely difficult without a payment source for services.

In closing, I wish to state that I honestly feel that the Department of Veterans Affairs is doing a great job caring for the needs of HIV infected veterans. It is the job of the VA to provide equal access to health care, regardless of lifestyles. I feel we are doing an admirable job providing medical, psychological, and substance abuse treatment, as well as helping veterans access benefits to which they are entitled.

I thank you for your attention and concern.

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AIDS Patient Registry – Demographic Update

Cumulative Totals to December 31, 1992

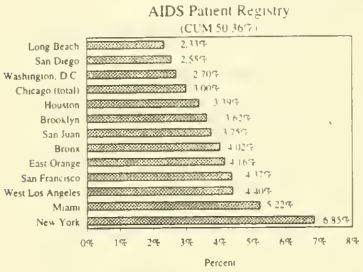
Cumulative total: 14,649

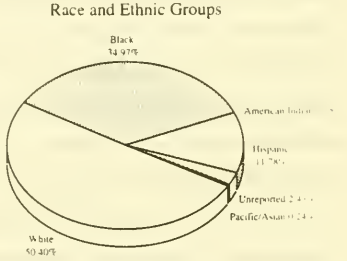
New patients reported in month noted

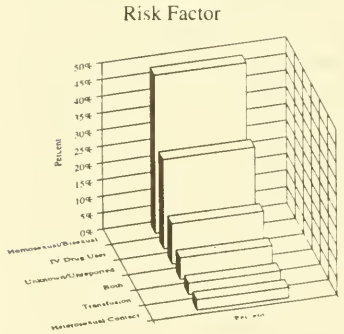
October	239
November	150
December	180
Year to date	2,241

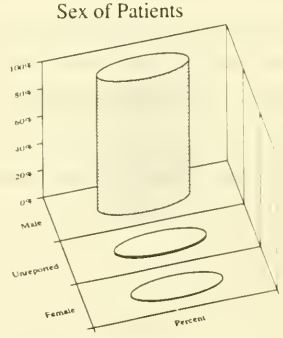
Risk Factor:	**Number**	**Percent**
Homosexual or Bisexual	6,980	47.65
IV Drug User	3,957	27.01
Both Homosexual & IV Drug User	954	6.51
Heterosexual contact	458	3.13
Transfusion (TRF)	511	3.49
Unknown or unreported	1,789	12.21

Ethnic:		
White	7,383	50.40
Black	5,123	34.97
Hispanic	1,725	11.78
Unreported	356	2.43
Pacific/Asian	36	0.24
American Indian	26	0.18
Sex:		
Male	14,411	98.38
Unreported	168	1.14
Female	70	0.48









AIDS and HIV Fact Sheet

United States:

- 253,448 people have been diagnosed with AIDS.
- 171,890 Americans — the combined populations of the cities of Worcester, Springfield, Cambridge and Chelsea — have died of AIDS related complications.
- By 1995, an estimated 500,000 Americans will have been diagnosed with AIDS and an estimated 330,000 to 385,000 people will have died of AIDS related complications.
- An estimated one million to 1.5 million Americans are infected with the Human Immunodeficiency Virus (HIV), the virus that causes AIDS.
- The CDC estimates that one in every 100 adult males and one in every 800 adult females is infected with HIV.
- Cases of AIDS transmitted by heterosexual sex increased 17 percent in 1992.

Massachusetts:

- 5,941 people have been diagnosed with AIDS in Massachusetts. Of those diagnosed, 63 percent, or 3,750, have died.
- AIDS is the leading cause of death among men aged 25-44 and a leading cause of death among women aged 25-44 in Massachusetts.
- One in 200 Massachusetts residents is infected with HIV and six more become infected each day.
- Massachusetts has the 10th highest AIDS caseload of the United States. Boston, New Bedford, Springfield and Worcester all rank among the top 100 American cities in total AIDS cases.
- One-fifth of Massachusetts AIDS cases are among people in their 20s and the majority of these individuals were infected during adolescence.

Boston:

- 2,160 Bostonians have been diagnosed with AIDS and 1,410 have died.
- Of all American cities, Boston ranks 14th in total AIDS cases reported.
- While heterosexual cases make up seven percent of the total U.S. AIDS cases, 11 percent of Boston's AIDS cases resulted from heterosexual transmission.

International:

- The Global AIDS Policy Coalition predicts that the number of AIDS cases in the world will increase tenfold over the next eight years, from an estimated two million in 1992 to 20 million by the year 2000.
- GAPC reports that 13 million people are currently infected with HIV and that by the year 2000, 38-110 million people will be infected.
- The World Health Organization reports that more than 75 percent of all cases worldwide were transmitted through heterosexual sex.
- WHO estimates that every 15 to 20 seconds someone becomes newly infected with HIV.

Sources: *HIV/AIDS Surveillance*, Centers for Disease Control, January 1993; *AIDS Newsletter*, Department of Public Health, March 1993; *AIDS in the World*, Dr. Jonathan Mann et al., Global AIDS Policy Coalition, 1992.

Revised 3/9/93

Statement of

GARY E. MAY

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University of Southern Indiana

Member, Board of Advisors
Agent Orange Class Assistance Program

Before the

Subcommittee on Oversight and Investigations
of the
House Veterans Affairs Committee

May 5th, 1993

Chairman Evans and Members of the Committee, thank you for inviting me to present testimony here today on the topic of "Health Care, Economic Opportunities and Social Services - A Vietnam Era Veteran Perspective".

My name is Gary May. I am a combat disabled Vietnam veteran, and I am a Certified Clinical Social Worker currently on the faculty of the University of Southern Indiana where I hold the position of Assistant Professor of Social Work. I serve as a member of the court-appointed board of advisors to the Agent Orange Class Assistance Program (AOCAP). The experiences which I and many others have had with the Vietnam veterans community through that program is what I would like to speak to you about here this morning.

In my testimony this morning I will be addressing some selected issues within the broad categories outlined in your hearing announcement which I believe, through my experience with projects funded by AOCAP, represent significant areas of unmet needs among Vietnam veterans and their families. The range of these needs is wide, and they cannot be met without a reconfiguration of existing resources and services as well as a reordering of the priorities and philosophy upon which existing programs are based.

The Agent Orange Class Assistance Program (AOCAP) was established to distribute a portion of the fund created by the settlement of the class action lawsuit by Vietnam veterans and their families against chemical companies which supplied herbicides used in the U.S. war effort in Vietnam. The Assistance Program provides funding through grants to non-profit organizations for programs and services of benefit to Vietnam veterans and their families. Approximately $42 million plus interest was made available for distribution under AOCAP over its seven year program life.

The Assistance Program operates under the direction and supervision of United States District Court Judge Jack B. Weinstein who supervises the Agent Orange settlement. The broad mandate of the program is to make grants to support organizations and services which address the needs and concerns of Vietnam veterans and their families. The Court has directed that the Assistance Program give priority to the concerns which gave rise to the original lawsuit -- providing services that are not currently available and bringing services to Vietnam veterans and their families who, for a variety of reasons, are not receiving needed assistance. For the purposes of the Assistance Program, the plaintiff class is treated as all persons who served in the Armed Forces in or near Vietnam between 1961 and 1972 and their spouses, children, and parents. A court-appointed committee of nine unpaid advisors from around the country, all but one of whom are Vietnam veterans, aids the Assistance Program in its planning and determination of priorities.

As the first grants were awarded in January, 1989, AOCAP and the Court set out to establish the broad program configuration with two key decisions made regarding the distribution of funding: 2

1. *No programs duplicating government funded services would be considered. The Assistance Program also established a policy prohibiting replacement of public funds, no matter what circumstances were involved, with settlement funds.*

2. *Since the settlement affected class members throughout the nation, AOCAP would strive to obtain the widest possible geographic distribution of the projects it recommended to the Court for funding.*

The program goals of the Assistance Program assumed final form and were approved by the Court in 1990. They have been reaffirmed by the Court and the Advisory Board in succeeding years. These broad goals focus in three major areas:

1. Services for Families. *Provide case-management and counseling to Vietnam veterans in the context of their families which takes into account the veteran's war experience as a major contributing factor to family dysfunction.*

As the Agent Orange plaintiff class includes the members of the veteran's family as equal partners, AOCAP programs must address the needs of the family as a totality.

2. Services for Children with Disabilities. *Build necessary links between the Vietnam veteran and Developmental Disability and other social services communities.*

Throughout the course of the Agent Orange litigation, plaintiff class members expressed concern for the health of their children. While it is not appropriate for the Assistance Program to judge the cause of any given disability, it is the responsibility of AOCAP to attempt to address the needs of these children and their families.

3. National Support Programs. *Establish a national support network, including a veterans law center, to provide technical assistance, training, and service linkages for the network of family services programs funded through AOCAP grants.*

The Assistance Program's emphasis on services to families and disabled children involves many agencies with varying missions and specialties. Serving the needs of Vietnam veterans and their families in the AOCAP context requires, among other things, knowledge of veterans benefits, the effects of PTSD, developmental disabilities, SSI and Medicaid. For this reason AOCAP supports a national network of programs which provide training and technical assistance to other AOCAP grantees as well as public and private agencies who may be providing services to Vietnam veterans or their families.

As funding for the Assistance Program was limited, both in terms of duration and amount, certain operating principles were adopted with the intent of maximizing and extending the impact of these settlement funds. Among these operating principles are:

1. Leveraging Resources

Given limited resources and the large size of the class, it is crucially important to use these limited dollars to leverage resources available through government and private agencies. It is an operating principle of AOCAP that Vietnam veterans and their families who are eligible for these programs and services can benefit greatly from quality case management and referral services to ensure equal access to those services and benefits which may already be available. This operational policy amplifies the effect of settlement funds, fosters development of clients' skills in using community programs and services, and represents a more holistic, integrated approach to serving people.

2. Networking Services

In serving a client population with needs as diverse as those of the Agent Orange Plaintiff Class, it has always been apparent that the range of human services necessary to meet their needs come from communities of service providers which have historically had only minimal contact with veterans at best. The Assistance Program is engaged in a number of efforts to bridge these gulfs and to encourage the development of relationships which are necessary to serve Vietnam veterans and their families in any comprehensive manner. Through AOCAP funding, much needed training and consultation is available to organizations in their particular areas of weakness.

B. Experience and Accomplishments -

In the nearly four years since the Agent Orange Class Assistance Program began, over $34 million has been disbursed in grant funds out of the proceeds of the settlement. AOCAP will come to an end in the middle of 1995, at which time over $65 million is expected to have been disbursed, including interest earned on the funds over the duration of

the program. To date, over 100,000 Vietnam veterans, their spouses and their children have been provided significant services through projects funded by AOCAP.

Currently, AOCAP funds seventy-six projects which are providing services in all fifty states plus the District of Columbia and Puerto Rico. Since the Assistance Program has established services to Vietnam veterans in the context of their families, with an emphasis on those families with disabled children as its primary program thrust, the organizations thus funded are a mix of agencies whose missions vary considerably. Fundamentally, these grantees may be divided into four distinct categories: veterans organizations, agencies serving the disabled community, community/family assistance organizations and national support projects.

1. Veterans Organizations. Veterans organizations comprise 35% of current AOCAP grantees. In addition to The American Legion, a major veterans membership organization, the Assistance Program provides funding to 23 community based veterans projects, whose primary mission is to meet the service needs of Vietnam veterans. Assistance Program grants have expanded the service capabilities of these organizations, which traditionally have provided help only to individual veterans. AOCAP funding has allowed these agencies to serve the broader needs of Vietnam veterans and their families, with particular emphasis upon services to children with disabilities.

2. Disability Services Agencies. Twenty-seven AOCAP programs are operated by agencies serving persons with disabilities. They include University Affiliated Programs for Children with Developmental Disabilities (UAPs), national disability organizations, parent advocacy agencies, and local chapters of organizations such as United Cerebral Palsy and the Association for Retarded Citizens.

3. Family Services Agencies. These 20 grantees include agencies whose primary mission is counseling, either general family therapy, or problem-specific services such as substance abuse recovery programs. Family assistance agencies have shown keen interest in participating in the Assistance Program since its beginning, and often specialize in case-management, a critical need of Vietnam veterans and their families.

4. National Support Projects. There are five national support projects which provide the core of the consultation, technical assistance, training and other support services to the network of AOCAP-funded community projects in order for those projects to access the tools, skills and expert advocacy necessary to serve individual clients. These projects range from the National Veterans Legal Services Project, with their expertise in the veterans benefits system and veterans law to the Access Group project of the United Cerebral Palsy Association and their state of the art knowledge regarding assistive technology for persons with disabilities. Each of these projects provides a significant level of direct services to Agent Orange Class Members as well.

With this mix of programs, AOCAP has completed its construction of a national network to address the needs of Vietnam veterans and their families, particularly those who have children with developmental or other chronic disabilities. In many of its aspects, the network operates with common operational guidelines, policies and program elements and with a substantial level of communication and cooperation.

AOCAP operates with a staff of eight in Washington D.C. plus one half time outstationed field representative. During the 1991-1992 program year (July 1 - June 30), AOCAP expended an amount for its own operational expenses equal to 6.47 % of its total disbursements for the year. It is anticipated that over the life span of the program, less than 8% of Settlement funds will be expended for such AOCAP administrative costs.

C. Lessons learned -

The staff and management of AOCAP, for the most part, come from backgrounds in veterans policy, programs and services. Even then, the learning experience for these personnel has been extensive, and in some

dimensions, profound and even difficult. In the areas of grant supervision and management, and particularly in the realm of program development and technical assistance, a number of important lessons have been learned:

1. *Integration of Services*

The strength of any human services project is greatly enhanced by its ability to marshall or access resources beyond its immediate program or agency boundaries on behalf of its clients through familiarity and relationships with public agencies or other private social services organizations. This is especially true of programs operated at the community level and through non-profit organizations, such as those funded by AOCAP. The strength and leverage available through the integration of services with other public as well as private services is something which has always been difficult to realize when dealing with government bureaucracies, however, and it is especially problematic in the realm of veterans services and programs.

AOCAP has funded agencies which have such strengths or have helped them design components within their projects to enhance their abilities to interface with a broad range of other service providers. Many of these projects have been able to construct service configurations for the benefit of Vietnam veterans and their families which are innovative, comprehensive and far more productive and effective than any strategies employed by the VA or any other strictly veterans' services agency in their attempts to assist many of the same clients. In most cases, AOCAP projects are now employing a true "systems approach" in the provision of services to Vietnam veterans and their families. Such a service protocol is certainly new and perhaps even radical as applied to this population. The effectiveness of this integrated or systems approach has been unquestionable.

2. *Family-Centered Service Strategies*

In evaluating early grants, Assistance Program staff began to recognize the high degree of dysfunction among many of the families served. Grantees further reported that the incidence of dysfunction often appeared to be directly related to Post Traumatic Stress Disorder (PTSD). This evaluation paralleled the findings of the National Vietnam Veterans Readjustment Study which reported that "...70% (of all Vietnam veterans with PTSD) have been divorced ... and 49% have high levels of marital or relationship problems." In addition, there has been a growing recognition of the impact of the veterans' PTSD on the psychological well-being of family members themselves. Currently, the Department of Veterans Affairs (VA) -- through its Readjustment Counseling Program -- provides very little family counseling. Thus, through its network of grantees, the Assistance Program is filling a large gap in treating the effect of PTSD on families and in bringing a family centered approach to bear on the problems of Vietnam veterans. A consistent finding by AOCAP-funded counseling projects is that, especially for Vietnam veterans, counseling strategies are only minimally effective if they do not include the family. This holds true even when PTSD is the central focus.

It has become apparent, through AOCAP's work with other human services communities, from those that deal nearly exclusively with the needs of children with developmental disabilities to those that are involved with the delivery of psychological counseling and therapy, that family centered service strategies is the norm in modern human services programs.

3. *The Importance of Case-management or Service Coordination*

Agencies funded by AOCAP, aside from any primary direct service thrust for which they may have initially sought funding such as family counseling, rehabilitation services or even medical care for children with disabilities, are required to provide case-management services. These case-management services, or service coordination as it is coming to be known in modern parlance, are rooted in a client-centered or empowerment model. Such services are also oriented toward the family, rather than toward any individual, whether that be the veteran or the child with a disability.

The Vietnam veteran population in need of services at present is essentially middle-aged, with a high incidence of dysfunctional families, psychological problems and alienation. These problems are usually multi-faceted, complex, and of a long standing nature. A central premise underlying the emphasis on case-management in AOCAP projects is that for such a population, it is probably only marginally effective at best to offer a single-faceted service such as counseling, rehabilitation or veterans benefits advocacy.

The elements of the case-management model employed by AOCAP grantees include: a) a comprehensive assessment of the needs of the veteran or family; b) the development of a service plan in cooperation with the client(s) to meet those needs, including time-lines; and c) regular and thorough follow-up, including structured family consultation to insure that the plan is being followed and is addressing the needs of the clients. As a general rule, case-management is carried out through a team effort, involving combinations of appropriate personnel from both within the agency or project itself as well as from other agencies or organizations.

Client-centered case-management, in addition to insuring a more appropriate, comprehensive and effective service configuration for an agency's clients, is the key to leveraging resources beyond that which may be available in direct program dollars. In the area of Supplemental Security Income (SSI), AOCAP programs have leveraged hundreds of thousands of dollars on behalf of Vietnam veteran families with children with disabilities. As SSI dollars also entitle a person to automatic Medicaid benefits in most states, this one outcome of AOCAP's emphasis on case-management has made tremendous differences in the well being of many Vietnam veteran families.

4. *The Benefits of Community Based Organization Service Delivery*

The AOCAP experience in providing grant funding for the delivery of human services to Vietnam veterans and their families primarily through non-profit community based organizations (CBOs) has been a revealing one, and remarkably smooth over the life of the program. The cost-effectiveness of the approach has been very high both in terms of cost per client served and in keeping agency administrative costs at a minimum. In some cases, the learning curve has been somewhat long and steep as many of the organizations funded by AOCAP had little if any previous experience in serving Vietnam veterans or their specific issues. Most organizations were able to accommodate to this new population very effectively, many by hiring a Vietnam veteran with experience in veterans services and benefits, and a good number of them were able to assemble an effective community advisory committee to help them deal with this very different target population.

In addition to these very important considerations, a number of other decided advantages to utilizing CBOs as a service delivery vehicle have become apparent:

a) A veterans CBO network exists in the US which, despite a lack of resources and a dwindling in numbers over the last decade, has become quite sophisticated in program management and service delivery. These CBOs, by and large already have the expertise to deal with the needs of Vietnam veterans, and can readily construct programs to deal with those needs utilizing a multi-faceted approach. This network represents a very valuable reservoir of expertise in dealing with the problems of veterans, particularly Vietnam veterans, and some close communications linkages have developed within it.

b) As CBOs, these organizations are well connected, by and large, into a broad-based network of human service providers on a local level through which a wide range of related needs of their clients can be addressed.

c) It is a hallmark of most CBOs that their program designs and even service configurations are very flexible, so that programs and services can be adjusted or even reordered with a minimum of effort to accommodate a new target population or to increase

their effectiveness in a particular service element such as counseling. They are obviously much less encumbered by regulations and procedures that are often impediments in the delivery of new services through programs run by the government.

d) The dedication and often even the professional qualifications are as high if not higher in the CBO world, by and large, than in the public human services sector, with state of the art, modern human services strategies well understood and employed as a matter of course.

D. Public Policy Implications

Public policy has long viewed the needs of returning veterans as specific to the individual. The traditional system of veterans benefits and services is veteran-directed, providing services and benefits to the veteran directly and with little regard to the veteran's family configuration, except for a variation in certain income allowances, with no services available to the veteran's family members from that system. Members of the veteran's family, characterized as "dependents," are recognized as having needs, in general, only if the veteran is disabled or deceased. Even the VA Readjustment Counseling Service, the "Vet Centers", designed to be more flexible and progressive in its service delivery approach, will deal with family issues only to the extent that they are an impediment to the veteran's "readjustment" counseling program.

The veterans' services system is also very badly fragmented; health care delivery is the exclusive province of a division within the VA which is wholly separate from vocational rehabilitation services, and veterans' counseling services are offered at separate locations from either health care or rehabilitation. Employment services are the responsibility of a separate agency altogether, with VA claims services provided by a variety of different agencies. Most tragically, there is little if any contact from within this fragmented array of services to the rest of the human services world. The lack of interface between outside human services services system and the programs and personnel engaged in the provision of veterans services has been nearly total. Professionals in these two fields speak different languages, it seems, and the programs they operate are based on almost totally different models of service delivery.

As the Department of Veterans Affairs has evolved into its current state - now a cabinet level department managing a $15 billion benefits administration and the largest medical care system in the world - its policies, programs and especially its human services strategies have often stagnated and become quite rigid. Its service delivery orientation is paternalistic and driven by the needs of the bureaucracy rather than the needs of its clients. In the meantime, the modern world of human services has evolved in size, scope, and has developed service strategies which are more effective, productive and responsive to the needs of clients.

The Agent Orange Class Assistance Program, as it operates under the supervision and direction of a Federal Court, is strictly prohibited from legislative advocacy in any form or manner. Therefore you will7not see the staff of the program engaged in lobbying for any broad legislative mandate or any specific legislative or budget item. Speaking as an individual, and as a professional with many years of experience in human services, however, I feel a need to articulate some general policy recommendations. These recommendations are extracted and distilled from numerous discussions at meetings of the AOCAP Advisory Board concerning the overall direction of the program, as well as from consultations and discussions with many AOCAP project staff which I have had the pleasure of meeting over the past four years. There is a general feeling shared by members of the AOCAP Advisory Board, the AOCAP staff and the directors of our projects that we have constructed a number of service models and strategies that work, and that this is the appropriate time to begin sharing those discoveries and innovations.

The following are a number of general veterans public policy recommendations which, once again, are based on the experiences

gained through the AOCAP network of programs, but are not rooted in any specific legislative proposals.

Integration of Systems and Services

Veterans' services at a Federal level should be better coordinated among the various agencies charged with such responsibilities, and the various services within the Department of Veterans Affairs itself should be reconfigured to accommodate more comprehensive service strategies. Equally important, a concerted effort should be made to develop service relationships and even agency agreements with appropriate state, local and community human service resources, both private and public, in order to more effectively address the needs of veterans and their families.

Inclusion of Families in Service Systems

The Department of Veterans Affairs in particular, and especially in the aspects of counseling, rehabilitation and vocational guidance programs, should be charged with reorienting its programs to consider the needs of the veteran in the context of his or her family, and to accommodate the needs of that family and family members where possible. If the previous recommendation is adopted, even in part, it will be found that modern human services parlance is couched in terms of family-centered service delivery and is the common orientation of most of these agencies at present.

Development of CBO resources

The Department of Veterans Affairs, as well as the Department of Labor programs for veterans should adopt strategies to maximize the interface and the contracting for services with appropriate community-based, non-profit human services agencies. Precedent for such CBO contracting is well established, and there are existing frameworks for service relationships which could be easily expanded. Besides the obvious advantages in terms of cost-effectiveness to this approach, this recommendation follows from, and is practically necessitated by the adoption of either of the above recommendations.

Skills Upgrading for Veterans' Services

The adoption of even parts of any of the preceding recommendations would necessitate the adoption of modern service strategies and especially counseling models. Intensive training and some re-configuration of existing programs would be imperative.

Thank you once again for the opportunity to present testimony before your Committee. I hope you find this testimony useful, and I would encourage you to consult and follow up with the staff of the Agent Orange Class Assistance Program on any of the points I have made in my testimony which might be unclear or need clarification.

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TESTIMONY OF

JOAN A. FUREY, R.N.,M.A.
ASSOCIATE DIRECTOR OF EDUCATION
DEPARTMENT OF VETERANS AFFAIRS
NATIONAL CENTER FOR POST TRAUMATIC STRESS DISORDER
CLINICAL LABORATORY AND EDUCATION DIVISION
VETERANS AFFAIRS MEDICAL CENTER
PALO ALTO, CALIFORNIA

BEFORE
THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATION
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ON

MAY 5, 1993

Testimony of
Joan A. Furey, R.N., M.A.

Mr. Chairman and members of the subcommittee. I am Joan A. Furey, R.N., M.A., Associate Director for Education at the Department of Veterans Affairs National Center for Post Traumatic Stress Disorder, Clinical Laboratory and Education Division located at the VAMC in Palo Alto, California. Additionally, I have been a member of the Chief Medical Director's Special Committee on PTSD since its inception in 1984, and during the past year have been placed on two VA National Task Forces focusing on issues related to the treatment of women veterans suffering from the psychological impact of sexual assaults which occurred while they were on active duty. I am also a Vietnam Veteran, having served in Vietnam with the Army Nurse Corp in 1969-1970., and have been an advocate for providing health care for women veterans for many years. I appreciate the opportunity to testify before you on issues related to the health care of women Vietnam Era Veterans.

As most of you are aware, there has been considerable concern expressed by female veterans regarding the adequacy of health care services provided for women by the VA. Among the issues identified over the past few years were those related to difficulties obtaining gynecological care and reproductive health care services, the availability of gender-specific services such as mammography and contraception, as well as the availability and quality of psychiatric and psychological services focusing on the emotional and sociological sequelae resulting from exposure to war-zone trauma. Most recently, we have all been made aware of similar concerns surrounding issues related to the physical and psychological aftereffects of sexual assault and harassment experiences that women veterans have been exposed to while on active duty.

Because women constitute a minority within a health care system that has been primarily geared towards men, women's specific health care needs have often received secondary attention by VA health care providers in the past.

Over the last few years, the VA has made demonstrable progress in improving the health care available to women veterans in both the mental health and primary care areas, and with the support of the Congress is actively involved in the planning and implementation of new programs that will further enhance the quality and number of services available for women veterans.

As the study of Post-Traumatic Stress Disorder has progressed several major advances in the assessment and treatment of individual suffering from this disorder have occurred: 1) the development of cognitive-behavioral theoretical formulations of PTSD; 2) recognition of the importance of exposure to war zone stressors in its development; 3) greater sophistication in developing constructs regarding potential interaction between individual characteristics and exposure to prior traumatic experiences, 4) the degree of exposure and its impact on symptom severity;

5) a greater understanding of the neurobiological alterations associated with PTSD and the implications for pharmacological treatment; 6) recognition of the high prevalence of the presence of other psychiatric disorders and/or emotional disturbances such as depression and substance abuse in this population; and 7) the recognition of the importance of development of valid and reliable measures of both stressor events and symptomatology for use with epidemiological as well as clinical samples. The literature on rape-related PTSD is much less advanced in comparison, although considerable work has been done in generally assessing the impact of rape in the general female population and more attention is now being given to the treatment needs of this population.

The importance of this work in the impact of sexual assault on women cannot be overlooked in its relevance to the mental health care needs of women veterans. The research findings of the Women's War Zone Exposure Study (Wolfe, Furey, Brown, Levin, 1990) which surveyed 200 women Vietnam era veterans showed that in addition to being exposed to significant stressors associated with a war zone setting, more than one in four of the female Vietnam Veterans (29.6%) surveyed had experienced at least one episode of sexual assault. It should be noted that the population surveyed were self-selected in the fact that they have identified themselves with veterans organizations, and made themselves available for study; however the number is high enough to alert us to this as an area of concern. Additionally, the recent testimony by women veterans before the US Senate Veterans Affairs Committee (June, July 1992), there is a clear indication that there is a percentage of women veterans who are survivors of sexual assault that occurred while they were on active duty. During the hearings, both survivors of and experts on sexual assault identified a number of factors that negatively impact on a rape victims willingness to report the event, and/or the military's response to the fact of its occurrence, that can contribute to the psychological difficulties women may experience following such a traumatic event. Unfortunately, due to the lack of research on women military personnel and women veterans we do not know with any specificity what the incidence of sexual assault/harassment is in the women veteran population. However, following these hearings it became evident that the VA needed to develop a systematic approach to providing care to women veterans affected by such incidents.

In 1991 the VA funded and supported the opening of the first PTSD in-patient treatment program specifically designed for women war zone veterans at the National Center for PTSD's Clinical Laboratory and Education Division at the VAMC in Palo Alto, California. When it opened in July of 1992 the program was designed specifically to treat war zone veterans. However, as more women veterans suffering from the psychological impact of sexual assault have presented for treatment at VA facilities their has been an increased awareness on the part of VA clinicians of the impact of sexual assault experiences on women veterans. This awareness has resulted in an increasing demand for both in-patient and out-patient treatment services for sexual assault survivors. As a result, our in-patient treatment program was recently redesigned to

accommodate the treatment needs of this population, and we have begun to accept patients requiring treatment related to assault experiences. Our program provides state-of-the-art diagnostic assessment, evaluation and treatment for women veterans of all eras. To date we have provided treatment to women who served in both the Vietnam War and the Persian Gulf, as well as veterans from the Korean war era, and post-Vietnam era. We have also started an outpatient group for women who do not require or are not yet comfortable with the idea of in-patient treatment. Unfortunately, we have found that among our treatment-seeking female patient population, experiences of significant sexual assault and/or harassment while on active duty is more the rule than the exception. This is true regardless of the era in which they served, whether they served in a war zone or remained in a stateside assignment.

Additionally, The National Center for Post-Traumatic Stress Disorder under the direction of Dr. Matthew J. Friedman recently funded the establishment of a new division within the Center. The Women's Health Science Division, located at the VAMC Boston under the direction of Dr. Jessica Wolfe, is the first of its kind in the country. I would like to underscore the fact that the directors of the various divisions of the National Center, Dr. Dennis Charney, Dr. Terence Keane, and Mr. Fred Gusman, recognized the need for such an addition to the center and supported the allocation of funds designated for distribution to their divisions to support the opening of the Women's Division. The National Center received no additional increase in its annual budget to support this initiative. While research and educational programs at the National Center have included women veterans, the Women's Health Science Division will be devoted exclusively to researching and studying the effects of traumatic stress on women veterans' mental health and physical well-being. This will include problems caused by sexual harassment and sexual assault. In collaboration with the Menlo Park Division, the National Center will be offering a broad range of of educational and training activities for professionals in the VA and the community designed to improve the assessment, diagnosis and treatment of PTSD in women.

The Women's Advisory committee headed by Dr. Susan Mather is also quite cognizant of the need for increased sensitivity regarding women's issues among VA personnel and has incorporated training initiatives into her strategic plan for women's health services within the VA. The overall commitment of the VA to improving women's health care was demonstrated by the major training conference it sponsored for VA health care providers held in Birmingham in September of 1992. Since that time, many VAMC's and regional offices of Readjustment Counseling Service (RCS) have held local conferences on women's health care issues. Further expansion of activities geared towards improving both the physical and psychological care available to women veterans has occurred as a result of the additional funding received to assist the VA in implementing the Veterans' Health Care Act of 1992. This Act; Public Law 102-585, allotted $7.5 million to assist the VA in improving health care services for women veterans. Under the direction of Dr. Susan Mather, ACMD for

Environmental Affairs, various initiatives are currently underway. These include supplementing the budget of RCS to allow for the placement of 1/2 time counselors, specifically trained in the treatment of women sexual assault victims, in over 60 Vet Centers across the country, and the designation of one FTEE to coordinate these services. A similar supplement has been provided to Mental Health and Behavioral Science Service who are now in the process of setting up 4 Pilot programs to develop similar mental health services within VAMC's. Other initiatives include the assignment of a full-time women veterans coordinator within each Regional office to oversee activities within the region and a pilot program that will result in 15 VAMC's receiving funding to support a position for a full-time Women Veterans Coordinator. Additionally, there will be 4 Comprehensive Women Health Care Programs developed, that will combine primary care and mental health services for women; and the development of a 3 year training program for VA health care professionals in treatment issues in women veterans. Until these initiative are actually in place however, it is difficult to assess the impact they will have on women's health care within the VA. Of particular concern is the care available to women veterans residing in rural areas and/or other communities where their numbers are few and services are limited.

I am pleased to state that I have been placed on both the VA's National Task Force on Sexual Assault Issues in Women Veterans and the National Training Program's Oversight Committee. To date, we have already formally planned two National TV Satellite Broadcasts (scheduled for May 12 and September 22) focusing on the diagnosis, assessment and treatment of sexual assault survivors, and are finalizing plans for a National Training Conference on Women Veterans Health Care to be held in Baltimore this July. We are optimistic that these initiatives will go a long way towards providing the education, training and sensitivity needed to continue to upgrade our health care services for women veterans. Clearly, in reviewing women veterans utilization of VA facilities, it is obvious that those facilities that demonstrate sensitivity to both the psychological and physical needs of women are the most successful in attracting women veterans to their settings. This seems to be so whether we are talking about a VA medical center, outpatient clinic, mental health center or Vet center.

Finally, the status of research related to women has received some attention for the VA. As of October 1, 1992, the Research and Development Program expended $1.3 million on research related to the health care of women veterans. An additional $4.8 million of non-VA appropriated funds has been awarded to VA researchers from other governmental and private sector organizations. Thus, in this time period $6.1 million was expended by VA investigators on research relevant to the health care of women veterans. Additionally, since May 1991, it has been VA policy that all applicants for VA research must consider (and document) the inclusion of women in their proposed study; and in August of 1992 the Office of Research and Development and the Health Services Research and

Development Service sponsored a conference for researchers, clinicians, and policy-makers to discuss VA's research agenda related to women.

Section 109 of P.L. 102-585 authorized 1.5 million to foster and encourage the initiation and expansion of research relating to the health of women veterans. However, these funds have not been appropriated.

In reviewing these activities, most of which have occurred within the last 2 to 3 years, it is evident that the VA has made demonstrable progress in improving the health care available to women veterans in both the mental health and primary care areas and has many new initiatives in the planning stages. As with any newly developing programming, I think it is essential that these efforts be sustained over time to assure that progress continues. The implementation of an organized evaluation and reporting mechanism is therefore essential to the monitoring of the impact of these initiatives on women's health care.

It is my hope that the committee will continue to focus on the needs of women veterans and that you will support enhancement of the VA's current programs as needed to assure that women veterans receive the benefits and health services that they have earned.

Mr. Chairman, this concludes my remarks, thank you again for the opportunity to address the subcommittee. I will be glad to answer any questions you may have.

TESTIMONY OF JONATHAN SHAY, M.D., PH.D.
Cambridge, Massachusetts

Petition for blanket upgrade of all combat veterans with "bad paper" to discharges that are eligible for VA services and benefits

Profile of the witness: Dr. Shay is a psychiatrist who specializes in the treatment of combat veterans with Post-traumatic Stress Disorder (PTSD). He is internationally known for his work on the cultural background of combat trauma and is author of *Achilles in Vietnam: Combat Trauma, Homer's* Iliad, *and the Ruins of Character*, forthcoming from Atheneum early next year. He has also published on the pharmacotherapy of PTSD and is on the Ethics Task Force of the International Society for Traumatic Stress Studies. He is on the faculty of Tufts Medical School and is a part-time employee of the Department of Veterans Affairs Outpatient Clinic in Boston. However, his testimony reflects his views as a private citizen, and not as a representative of the Department of Veterans Affairs. He is present at his own expense, not the Government's. His complete credentials found at the end of the written testimony.

ORAL TESTIMONY

I feel deeply *ashamed* that there are *combat* veterans who are not eligible for VA services and benefits. Virtually all of these veterans committed offenses *after* combat that caused them to be discharged from military service under less than honorable conditions (what veterans call "bad paper").[1] As an expert in combat Post-traumatic Stress Disorder (PTSD) in Vietnam combat veterans, I can tell you that most combat veterans with "bad paper" committed infractions **as a result of psychological injuries incurred in their combat service**. Typical offenses stemming directly from combat PTSD were:

- AWOL or desertion after return to U.S.
- Use of illicit drugs to self-medicate symptoms of PTSD
- Impulsive assaults during explosive rages on officers or NCOs after return to the U.S.

These veterans had no treatment then, and have no treatment now for their Post-traumatic Stress Disorder or for its complications of substance abuse, depression, and violence. They have been profoundly disadvantaged in finding work and probably comprise a disproportionate fraction of homeless veterans, who make up one-third of all homeless men.[2]

I am *not* asking for a study. I am *not* asking for an expansion of the existing case-by-case discharge upgrade program. Today I ask Congress for a blanket upgrade of all veterans discharged under less than honorable conditions who have *any* combat decoration: such as

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[1] According to DVA policy veterans with General Discharges are to be treated the same as veterans with Honorable Discharges. However, I have been told repeatedly by veterans that in some parts of the country veterans with General Discharges under less than honorable circumstances are turned away, unless they know how to work the system. A blanket upgrade would eliminate this misadministration of the existing policy.

[2] National Coalition for the Homeless, "Heroes Today, Homeless Tomorrow?: Homelessness among Veterans in the United States." 1621 Connecticut Ave., NW, Washington DC 20009, November, 1991. Pp. 6ff.

Combat Infantryman Badge or obviously any award for heroism, such as the Bronze Star. I have spoken to many Vietnam combat veterans with Honorable Discharges about this, and not one has felt that this would diminish them in any way. Their reactions have all been either "It's about time" or "There, but for the grace of God, go I."

What I propose applies *only* to combat veterans, who constitute but a fraction of the 566,000 Vietnam-Era veterans with General, Undesirable, Bad Conduct, or Dishonorable discharges.[3] I estimate the number of Vietnam vets who would be eligible to be between 10,000 and 50,000. I have no estimate for other wars. I *treat* veterans with psychological injuries from their war service, and I find the situation of veterans with "bad paper" to be as *unjust* and *irrational* as if they had been drummed out for failure to stand at attention after their *feet* had been blown off. Most of these men committed offenses *because* of their combat PTSD.

Pure self-interest should lead us to take this step, even if a sense of justice does not. Between a tenth and a quarter of all incarcerated males are veterans.[4] It costs an average of $25,000 a year for each of these, and this does not include the monetary costs to society of the criminal acts themselves.[5] Unhealed combat PTSD predisposes to criminal justice involvement;[6] and treatment costs but a fraction of the costs to *wait* for crime to happen and then use the police, courts, and prisons to "*treat*" it.

I would now like to introduce Warren Quinlan, Director of Shelter Operations for the New England Shelter for Homeless Veterans, a 150 bed non-profit veteran-run shelter in downtown Boston. He will give you profiles of some highly decorated homeless veterans who have been ineligible for VA services and benefits because of "bad paper." These case histories will illustrate the public health and public safety problems of leaving their mental and physical health problems untreated.

ADDITIONAL WRITTEN TESTIMONY

Neglected communicable diseases such as tuberculosis impose ever increasing public health risks and costs. Veterans with PTSD are more than five times as likely to be homeless and vagrant than

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[3] Lawrence M. Baskir, William A. Strauss. *Chance and Circumstance: The Draft, the War and the Vietnam Generation.* New York, Vintage Books, 1978. Pp. 218f.

[4] This is a commonly used figure, but the data are very poor on this subject. Incarcerated Vietnam veterans in particular are reluctant to disclose their military records to correctional officials.

[5] *NVVRS VII-20-1, -2* 36.8% of veterans with PTSD self-reported six or more violent acts in the preceding year compared to 11.5% of demographically similar civilian controls.

[6] *NVVRS VII-21-1, -2* 34% of veterans with PTSD self-reported 2 or more arrests, and 11.5% reported conviction for a felony. The corresponding percentages for demographically similar civilian controls were 6.8% and 4.9%

demographically similar civilian controls,[7] thus more effective in spreading communicable diseases. Untreated substance abuse endangers both public health and public safety.

I am not so naive as to think that if I knew *every* combat veteran with bad paper, I would feel that every one of them "*deserves*" an Honorable Discharge. I probably would not. But *this* is the point of my testimony -- that the terror, grief, rage, and *betrayals* of prolonged, heavy combat can *ruin* good character. The damaged character of some combat veterans *is* a war injury. We are neither just, nor serve our own best interests when we deny these veterans treatment to heal these damages in their character.

To deny any *combat* veteran the physical and mental health services of the VA is not only unjust, it is self-defeating. It is bad public policy.

CURRICULUM VITAE
Jonathan Shay M.D., Ph.D.

Born, Philadelphia, PA, November 16, 1941.

Education:

Lawrenceville School, Lawrenceville, NJ		1959	
Harvard College, Cambridge, MA	BA	1963	
University of Pennsylvania, Philadelphia, PA	MD	1971	
University of Pennsylvania, Philadelphia, PA	Ph.D.	1972	(Neuropathology)

Positions:

1972 - 1977 Assistant in Neuropatholgy in Neurosurgery, Massachusetts General Hospital, Boston

1974 - 1977 Principal Investigator, "CNS oxygen and/or glucose lack in vitro." U.S. Public Health Service, National Institute of Neurological Diseases and Stroke

1975 - 1977 Director (1975-1976 Co-Director), Mixter Laboratory, Neurosurgical Service, Massachusetts General Hospital

1976 - 1977 Section Head, "In vitro studies on mechanisms of ischemic damage to cells", Program Project: "Cardiopulmonary function in remedial vascular disease", Alex Leaf, M.D., Principal Investigator

1976 - 1977 Assistant Professor of Pathology, Harvard Medical School

1977 - 1980 Resident, Psychiatry, New England Medical Center Hospital, University Hospital, and Boston City Hospital, Boston

1987 - Psychopharmacology Fellow, Tufts Medical School, Department of Psychiatry

1987- Staff Psychiatrist, Day Treatment Center of the Veterans Administration Outpatient Clinic, Boston, MA

1988- Team Psychiatrist, Veterans Improvement Program (PTSD), Veterans Administration Outpatient Clinic, Boston, MA

Awards and Honors:

1963 Magna cum Laude, Harvard College

1969-1972 Life Insurance Medical Research Fund M.D.-Ph.D Scholarship

1971 Alpha Omega Alpha, University of Pennsylvania Chapter

1985, 1986 Selected in competition for Bread Loaf Writers' Conference

Societies:

Past memberships: American Association for Research in Vision and Ophthalmology, American Society for Cell Biology, American Association of Neuropathologists, International Academy of Pathology

Current memberships: International Society for Traumatic Stress Studies, American Association for the Advancement of Science

Publications (partial list):

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[7] *NVVRS VII-18-1, -2*

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Shay, J. *Achilles in Vietnam:Combat Trauma, Homer's* Iliad, *and the Ruins of Character*. New York: Atheneum, 1994. Forthcoming.

Peer-reviewed presentations in psychiatry:

Shay, J. (1989) Fluoxetine reduces explosiveness and elevates mood of Vietnam combat vets with PTSD. 5th Annual Meeting of the Society for Traumatic Stress Studies, San Francisco, CA

Munroe, J., Shay, J. & Clopper, M. (1989) Creating a family of re-origin: A long term outpatient PTSD unit. (Pre-meeting Institute) 5th Annual Meeting of the Society for Traumatic Stress Studies, San Francisco, CA.

Shay J. (1990) Learning about combat stress from Homer's *Iliad* 6th Annual Meeting of the Society for Traumatic Stress Studies, New Orleans LA.

Munroe, J., Fisher, L., Shay, J., Rapperport, K., & Makary, C. (1990) Trust and team techniques in treating Vietnam combat veterans. (Workshop) 6th Annual Meeting of the Society for Traumatic Stress Studies, New Orleans LA.

Shay, J., Fisher, L. (1990) Group therapy of repetitive combat dreams. 6th Annual Meeting of the Society for Traumatic Stress Studies, New Orleans LA.

Munroe, J., Shay, J., & Rapperport, K. (1991) Ethics of eliciting trauma histories for use by therapist outside the ongoing therapeutic relationship. (Workshop) 7th Annual Meeting of the International Society for Traumatic Stress Studies, Washington DC.

Shay, J. (1991) Soldiers' Griefwork in Homer's *Iliad* and by Americans in Vietnam: A Cross-cultural Comparison. 7th Annual Meeting of the International Society for Traumatic Stress Studies, Washington DC.

Shay, J. (1991) Soldiers' weeping: Cross-cultural comparison of the social valuation of grief in Homer's *Iliad* and by Americans in Vietnam. 7th Annual Meeting of the International Society for Traumatic Stress Studies, Washington DC.

Shay, J. (1992) Achilles in Vietnam: Learning about Combat Trauma from Homer's *Iliad*. First World Meeting, ISTSS, Amsterdam, The Netherlands

Shay, J. (1992) A practical psychopharmacology of combat PTSD. First World Meeting, ISTSS, Amsterdam, The Netherlands

Shay, J. (1992) Social dimensions in pharmacotherapeutics for combat PTSD. First World Meeting, ISTSS, Amsterdam, The Netherlands

Munroe, J., Fisher, L., Shay, J., Rapperport, K., Makary, C. (1992) Surviving Trauma Work: Cultivating Support, Working Relationships, and Alliances. (Workshop) 8th Annual Meeting of the International Society for Traumatic Stress Studies, Los Angeles

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TESTIMONY OF WARREN QUINLAN

Boston, Massachusetts

Petition for blanket upgrade of all combat veterans with "bad paper" to discharges that are eligible for VA services and benefits

ORAL TESTIMONY

I will present the problems of the combat veteran with "bad paper" from the perspective of having worked with the 3,000 homeless veterans who resident for at least one night in the New England Shelter for Homeless Veterans during the last three years.

ADDITIONAL WRITTEN TESTIMONY

Separately, combat PTSD is a social and legal problem; and veterans with "bad paper" are a social and legal problem. The two together produce a dangerous and intractable morass of criminal, civil, and domestic dreadfulness. In the overall Vietnam Era veteran population of about 8.6 million, only three percent were discharged with Bad Conduct, Undesirable, or Dishonorable Discharges, yet on any given day, an average of about 50% of the men coming through the doors of the New England Shelter for Homeless Veterans have such "bad paper." *Half*, or 25% of these are combat veterans. Since only 9% of the overall Vietnam veteran population were combat veterans,[1] what the Shelter sees demonstrates the nearly three-fold amplification of social pathology that direct participation in war causes.

The Shelter has a staff of volunteer lawyers and law students who assist homeless veterans with case-by-case discharge upgrades, but their experience is similar to the experience nationally: that the existing case-by-case process takes an average of one and one-half years comprising many separate administrative steps for the veteran. Without

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[1] 766,000, using the definition as "High Combat Stressor Exposure" from the Congressionally mandated *National Vietnam Veterans Readjustment Study* (*NVVRS*) as the criterion for a combat veteran. *NVVRS* collected data on type of discharge and combat exposure, but cross-tabulation of these data has not been published. Combat veterans with bad paper are characteristically even more mistrustful and more hostile to the government than other Vietnam combat vets (who as a group are quite mistrustful of the government), so we should assume that they are systematically under-represented in the *NVVRS* sample, first because of difficulties in simply finding them and second in terms of gaining their cooperation in the study. It should not be surprising, therefore, that the percentage of veterans with less than General Discharges measured by the *NVVRS* was considerably lower than the percentage derived from the Armed Forces own reports of such discharges.

legal assistance, no veteran can request and interpret the relevant regulations at the time and now, find and interpret the relevant case law, and prepare a memorandum applying these to the facts, drawing the legally meaningful conclusions. As a practical matter for a homeless man, this means that his prospects for upgrade, even *with* assistance, are essentially zero, because of the extended time and multiple steps involved. To tell them that there is a case-by-case discharge upgrade program is a cruel joke. For them it is simply another sham, another lie told to them by the land for which they fought.

These men have no way out, no way up. *If* they receive psychiatric care at all, it is in overburdened state mental hospitals and municipal general hospitals, where they can expect little understanding of the distinctive problems of combat PTSD. The only reservoir of combat PTSD expertise, the VA, is closed to them because of their bad paper.

I take pride in appending to my written testimony a letter and proposal for an Executive Order sent to President Clinton by the Executive Director of Shelter Legal Services Foundation. This foundation was founded by two law students in 1991, in response to the numerous legal problems of homeless veterans. It has since expanded to 50 volunteer attorneys and 200 volunteer law students and serves residents of the New England Shelter for Homeless Veterans and Rosie's Place, a homeless and battered women's shelter in Boston.

SHELTER LEGAL SERVICES FOUNDATION, INC.
885 Centre Street
Newton, MA 02159-1156
617-552-0623

April 30, 1993

President Clinton
The White House
100 Pennsylvania Avenue
Washington, D.C. 20420

RE: PROPOSAL FOR AN EXECUTIVE ORDER TO UPGRADE MILITARY DISCHARGES FOR HOMELESS COMBAT VETERANS

Dear President Clinton:

We write this letter and proposal on behalf of the Homeless Veterans who are slowly dying on America's streets. Our organization has provided legal represenation to hundreds of homeless veterans from the Greater Boston area. Our association with homeless veterans has led us to discover that about 50% of these veterans have military discharges that are less than a General Discharge. We further discovered that over 25% are combat homeless veterans with less than a General Discharge. Because of this discharge, over 1/4th of the homeless veteran population is denied health care, job training, education, and financial benefits from federal, state, and local veterans agencies.

It is an American tragedy that one who has given so much to our country now suffers because of the discharge he or she has received from the military. There is a system in place for military discharge upgrades, however, for the homeless veteran this system is only a myth. The system takes anywhere from one year to a year and half before the military discharge is upgraded or declined. Time in effect discriminates against the homeless veteran because of the transient nature of homelessness, the lack of an address, and discouragement. Action must be taken in order to improve the chances for a homeless veteran to be incorporated back into society.

We have enclosed a proposal for your consideration. We believe that an Executive Order will not only greatly help the homeless veteran, but also further your goal for changing what is wrong with America. In closing, we want to relate a story about America's two sons as told by Warren Quinlin, Director of Shelter Operations for the New England Shelter for Homeless Veterans, who will testify before the House Veterans Affairs Oversight Sub-Committee on May 5, 1993.

The first son heard his country's call to arms and fought in the Viet-Nam War where his sweat, blood, and tears fell upon the jungle battlefield. The effects of the war took its toll on the first son who was highly decorated for bravery, however, was discharged from the service with a Bad Conduct Discharge because he struck his commanding officer.

The second son served his country by protesting the war. He organized students, rallies, and marches to end what he strongly believed was an unjust war. When his country called him into the armed service, he fled to Canada.

Coming home for the first son was bitter. He encountered protesters at the airport who belittled him and spat on his face. On the other hand, the second son was blessed by a Presidential Pardon from President Carter. He was allowed to come home as a hero because his war was vindicated.

Thank you for your time and consideration.

Sincerely,

_____
Manuel Duran
Executive Director

_____
Sean W. Mullaney
President
Board of Directors

Enclosures

MD:cg

SHELTER LEGAL SERVICES FOUNDATION, INC.
885 Centre Street
Newton, MA 02159-1156
617-552-0623

PROPOSAL FOR AN EXECUTIVE ORDER TO UPGRADE MILITARY DISCHARGES FOR HOMELESS COMBAT VETERANS

Proposal: Executive Order granting all combat veterans a military discharge upgrade to a General Discharge under Honorable Conditions for all veterans who served in combat duty in World War II, Korea, Viet-Nam, Dominican Republic, Lebanon, Grenada, Panama, and the Persian Gulf.

Purpose: To provide homeless veteran access to much needed assistance from federal, state, and local veterans benefits such as health care, education, job training, and financial assistance.

Impact: Implementing this domestic policy through an Executive Order impacts across various goals of President Clinton's Administration.

1. Political:

a. Public opinion of the President will be very favorable due to the public's sympathy for homeless veterans.

b. Immediate action such as an Executive Order will signal to the public your commitment to helping those who have given so much to America, and today have nothing.

c. Improve relations with the military because of the demonstrated care for the soldier.

d. Dispel the myth that only the Republicans take care of the veterans.

2. Health Care: Demonstration of President Clinton's resolve to improve America's Health Care System by providing access to VA Hospitals for thousands of homeless veterans who have been denied health care because of their military discharge.

3. Social: There are an estimated 375,000 to 400,000 homeless veterans across the United States. From the experience we have had at the New England Shelter for Homeless veterans, approximately 25% are combat veterans with discharges from the military below a General Discharge. Making an Executive Order to upgrade the homeless veteran's military discharge will have a great positive impact against homelessness in America's streets.

4. Economic: This policy will not require a government project to implement. The existing structure of the Department of Veterans Affairs should be able to absorb any possible flood of applicants for discharge upgrades. Homeless shelters and veterans organizations can be enlisted as volunteers to help the homeless veteran with the application process. The cost to the government will be minimal when taken into perspective the cost that homelessness has on society. Helping the homeless veteran now with health care, education, job training, and financial assistance is less expensive than allowing the homeless veteran to live in the streets unassisted where he will be in and out of jail, not contributing to the economy, and, eventually the ultimate tragedy and cost, die because of starvation, drug overdose, or hypothermia.

5. Military Discipline: This Executive Order will in no manner affect military discipline. A combat veteran in the military will still be subject to military punishment. The discharge will be the only difference in the sentencing of a combat veteran on active duty. A soldier who commits a crime will still have that crime on his or her criminal record. Furthermore, this Executive Order is not intended for those who commit capital offenses unless there are such mitigating circumstances such as Post Traumatic Stress Disorder.

TESTIMONY SUBMITTED BY

Ms. Mary Helen WhiteEagle

For Presentation Before

Subcommittee on Oversight & Investigations
House Committee on Veterans Affairs

May 5, 1993

Being here does not make me represent any veterans in Indian Country. I have conversed with several Vietnam Era Veterans, most of the comments have been "Who asked you to participate?", "You are not a veteran of Vietnam Era", "I will not be forced to speak out", "It's been a long time ago". But I feel it's better late than never.

In 1992, with the passage of Public Law 102-218 creating an Office of Chief Minority Affairs within the Department of Veteran Affairs, it just made the Indian and Alaskan Native veterans a "minority within a minority". As far as I know there are no American Indians or Alaska Natives employed in this office.

Despite the fact that a approximately 10,000 American Indians and Alaska Natives served in World War I, over 25,000 in World War II with many joining new recruit in Korea and an estimate of over 42,000 American Indians and Alaska Natives servicemen stationed in Southeast Asia, very little attention has been given to the problem of American Indians and Alaska Native veterans in general and particularly for those who served in the Vietnam War. Some considered the American Indians and Alaska Natives outside the mainstream and have considered research studies of Vietnam veterans "insignificant".

The services of the Veterans Administration has been inappropriate. In 1983 a study was done by a task force and a very low percentage sought services within the centers, only 62% knew of the type of services that existed. Some of the reasons for seeking the Veteran Center services were: 1) Substance Abuse 10.6%, 2) Employment 21%, 3) Agent Orange 6.4%, 4) Education 12.8%, 5) Discharge Upgrade 2.1%, 6) Violence 4.3% and 7) Combination 17%. Out of the percentage only 55% were satisfied, 13% were not satisfied and 32% were mixed.

Numerous veterans have suffered stress-related symptoms and suffer from problems associated with their wartime experience. Symptoms sufferers complain of feelings of rage, depression, spontaneous flashbacks of combat, sleep disturbance, intrusive recollection, survivor guilt and heightened startle responses.

The need of all veterans, regardless of their cultural background, is to achieve some sort of integration of their combat experience. For American Indians and Alaska Natives this need is particularly acute because the cultural emphasis on them has been explicit rather than implicit. The veterans represent an extreme case of both in terms of cultural preparation and reintegration opportunities and problems. Therefore, their experience offer clinical observers difficult encounters.

The combat experience which established the warrior's identification as a warrior clearly is valued by the community as a whole.

There is no amount of money that can compensate for the damage that has been done for all veterans of all wars. But there's a lot we can do to rehab and service these and all veterans. There is a need to sensitize the Veteran Centers and Veteran Administration providers to the cultural difference of the American Indians and the Alaska Natives. The greatest problem nationwide has been to get the veterans to come in for counseling. This is greatly due to the centers and service providers being in the urban areas and are

inaccessible for many veterans living on the reservation and villages. The centers need to be able to locate reservations within their state or area of operation. Then employ networking strategy with different American Indian and Alaska Native organizations and emphasize training programs for reservations, villages and islands and extend the provider services.

A demonstration of sensitivity and concern along with the ability to provide services, or make referral will increase their credibility in the American Indian and Alaska Native communities.

I think there should be a clearing house or something that a person can contact for information, if there isn't already one.

I have observed at many pow wows offer unique opportunities to disperse information and to experience Indian and Alaska Native cultures, while noting the special place for veterans with the Indian society. This has also been a great communication for the veterans to express their combat experience and releasing many problems.

Despite the fact, many of the veterans have achieved relatively high education levels after military service. Many are in financial and emotional needs with about 46% remain unemployed. "From the American Indian perspective, war is viewed as a major disruption of the natural order of life and the universe. Only the most serious reason suffice for entering into this chaotic destruction. Those who partake in it risk serious danger on many levels. Often the warriors are in need of special preparation for the ordeal of the war, as well as cleansing and healing later, so they night once more become a part of the people."

To a lesser extent, war may be seen by a particular tribe as the ultimate testing ground of a warrior and to have partake in combat is to have had the opportunity to develop as a person. Those who partake in it are in need of recognition of their achievement and sacrifices and in need of closure so that there may be a separation of their roles as warriors in combat and their roles as warriors living among their people. The degree to which war is seen as such an opportunity for achievement varies widely among tribe.

A sense to reflects the need for reintegration back into their society. That need is deeply present in Vietnam Era Veterans whose culture place a religious and social expectation of the process of going to war and returning from war.

Total experience of Vietnam has been somewhat negative.

But the need is there to provide for all veterans let us assist each other and accomplish the things they fought for.

Thank You.

May 5, 1993

Lane Evans, M.C.
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Dear Congressman Evans.

It is an honor and a privilege to appear before this committee. I never dreamed that I would go from serving in Viet Nam to appearing before Congress in our nation's captal. In 1969 I was a young second lieutenant stationed at Ft. Lee, Va. I remember coming to this very building and standing on the steps filled with American pride. I am just as proud today.

I come before you today to discuss two ideas. Neither of these ideas ask our government to spend any money. Both ideas are based on the need to create jobs. Jobs that our veterans need. Jobs that will give our citizens the opportunity to pay taxes.

I am today here to endorse Velda Sue. Velda Sue has been supported by my Congressman, John LaFalce. I am also here to ask that we give some better definition to the term "Special Consideration" as it applies to veterans under 13 CFR Ch 13 Subpart A Sec. 116.3.

VELDA SUE

First I would like to discuss Velda Sue. Velda Sue is an idea that would create an agency simillar to the Federal National Mortgage Association. Velda Sue is intended to create a secondary market for Small Business Administration guaranteed loans. The ultimate purpose is to channel more capital into the SBA market. I stronqly support this concept. I have been a small business lender for most of my twenty year banking career. I can assure you that by channeling more capital into the SBA market we will grow the economic base of our country.

I would like to share one concern and then look at creating a special investment vehicle under Velda Sue.

In creating a secondary market in the residential mortgage area we now have a monster called the standard loan. If you, as a borrower, do not fit the "standard" your loan is in trouble. I am concerned because I have never seen a "standard" SBA loan. This concept of the standard needs to be fully explored before we create a monster that is full of promise but short on delivery. The veterans community has a lot of experience with frustration and Velda Sue need not add to that frustration.

I would also ask that as part of Velda Sue, steps be taken to separate loans to veterans. This separation would allow for a special investment category. Investment managers at all levels including veterans organization, mutual fund managers and Wall Street could then give Americans the

opportunity to directly support the veterans community by investing in the Velda Sue Veteran Loan. We may ever see a veterans loan mutual fund. The loans would carry the SBA Guaranty, be purchased at market rates and deliver much needed capital to the veterans community. The potential for jobs, the support for of the veteran entrepreneur and the growth of tax paying citizens could done without any direct federal expense.

SPECIAL CONSIDERATION

The Citizens Guide to CRA details 12 assessment factors. I have selected five factors that we can use to get the veteran some "Special Consideration" at the local bank. I have listed the factors. some comments on how this factor could be applied to the veteran and a note on the benefit including some local experiences.

Special Consideration according to the SBA SOP of 3/15/85 pages 20 and 21 follows:

" The special consideration criteria relating to financial assistance programs are as follows:

(1) In depth management assistance counseling on first interview.

(2) Prompt processing of loan applications of any type.

(3) In each district office there shall be one or more loan officers designated as veterans loan officers, as a collateral duty.

(4) Applications of veternas for business loans will be processed and funded ahead of other loan applications on the same day."

I can tell you from my experience in the Buffalo area this is happening. Our local SBA office meets these definitions of special consideration and in fact goes beyond the letter of the law with an active, spirited attitude that makes dealing with them a pleasure.

I want to see that same consideration at the local bank. I would like to see the Community Reinvestement Act applied to veterans and the SBA loan guaranty program. I believe that by expanding the coverage of a law that already exists we can ask the private sector to buy into the need to put more capital into the veterans community. In the following review ofselected CRA assessment factors I discuss the specifics.

Asessment Factor 1.

Activities conducted by the financial institution to ascertain the credit needs of its community, including the extent of efforts to communicate with members of its community regarding the credit services being provide by the institution.

Veterans Inclusion.

These activities could include seminars and meetings with veterans organizations. The subject matter could include information about small business lending policy and procedures.

Benefit.

Veterans frequently have lost touch with

their community while away in service. Their return to their community and to the business world is often colored by unrealistic expectations or bad information. The recent downsizing of the armed services will be putting large numbers of these veterans back into the mainstream economy. Meetings with local banks and bankers could enhance the entrepreneurial spirit of the veteran.

Assessment Factor 2.

The extent of the institution's marketing and special credit-related programs to make members of the community aware of the credit needs offered by the institution.

Veterans Inclusion.

The veteran generally has a special identification with another veteran. Banks could be encouraged to appoint a veterans loan officer. This appointment would follow the SBA's lead in having a designated veterans officer and could be highlighted in the banks special credit related programs.

Benefit.

My experience as a lender and a member of the veterans community frequently made me the informal veterans loan officer. This allowed me the opportunity to work with the veteran and develop a properly packaged loan request. The bank got a better customer and the veteran got a loan that could be paid according to terms.

Assessment Factor 8.

The institution's participation, including investments, in local community development and redevelopment projects or programs.

Veterans Inclusion.

Many veteran Community Based Organizations (CBO's) do not have an established communication link with their local bank. Many of the CBO's need assistance in developing funds management programs. Banks could be encouraged to meet with CBO's to establish a dialogue that would open new doors. CBO's frequently serve the needs of the homeless veteran. These meetings could be a springboard to developing projects with common ground. In Buffalo the Western New York Veterans Housing Coalition, Inc. began its operation with a small bank line of credit. Today the organization manages over thirty five units of low-moderate income housing and has nearly one hundred units in the development process.

Assessment Factor 9.

The institution's origination of residential mortgage loans, housing rehabilitation loans, home improvement loans, and small business or small farm loans within its community, or the purchase of such loans originated within its community.

Veterans Inclusion.

SBA loans to veterans could be included as an additional statistical measurement during a bank examination. Veteran status is available in the standard SBA application.

Benefit.

This measurement could be a positive boost for loans to the veterans community.

Assessment Factor 10.

The institution's participation in governmentally insured, guaranteed, or subsidized loan programs for housing, small business, or small farms.

Veterans Inclusion.

The inclusion of the veteran in this assessment factor expands the definition of the term "Special Consideration". It expands the SBA SOP into the private sector for the SBA loan guaranty program.

Benefit.

There is potential for two types of evaluation under this factor. First there is considerable discussion about the creation of Velda Sue. This factor could be understood to encourage the purchase of these investments. Second in the Buffalo market the Western New York Veterans Housing Coalition has built low and moderate income housing and created jobs. This was accomplished by a bank providing a credit accomodation that was in concert with long term loans from the City of Buffalo, the State of New York and the United States. Included were loans from Community Development Block Grants, the state Housing Trust Fund and the HUD 202 program.The cdredit accomodation could be defined as patricipation in programs for housing.

CONCLUSION

The implimentation these measures in the assessment factors could possibly be done with some administrative direction from the appropriate congressional committee to the varioous bank regulators. It does not cost the taxpayer any money and should encourage loans to veterans. The regulatory agencies could be encouraged by Congress to add veterans to the groups that CRA is intended to protect.

It is my belief that through encouraging the private sector to invest, or by creating vehicles for private sector investment we can expand the economy. I would ask that you look at the opportunities that both Velda Sue and CRA's expansion to include "Special Consideration" can create and at what these ideas don't do to the national debt.

Thank you for this opportunity.

William C. Lyons

"PARTICIPATION DELAYED & PARTICIPATION DENIED"

TESTIMONY OF

JOHN K. LOPEZ, CHAIRMAN

ASSOCIATION FOR SERVICE DISABLED VETERANS

MAY 5, 1993

HONORABLE LANE EVANS, CHAIRMAN

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

COMMITTEE ON VETERANS AFFAIRS

UNITED STATES HOUSE OF REPRESENTATIVES

CANNON HOUSE OFFICE BUILDING

WASHINGTON, D.C.

Mr. Chairman and members of the U.S. Congress, I wish to thank you for this opportunity to present testimony regarding the "Concerns of the United States Veteran."

The Association for Service Disabled Veterans (ASDV) is a non-profit organization started in 1985 at Stanford, California.

The ASDV has no paid staff, all support is by unpaid service disabled and prisoner of war veteran (SDV) volunteers and activity specific donations by individuals and private sector corporations.

ASDV concentrates its activities on the needs and aspirations of those service disabled and prisoner of war veterans that are supplementing their rehabilitation by being owners and managers of smaller businesses. In that respect, we have sponsored six (6) State of California legislative acts pertaining to SDV economic participation in State of California Agency and related organization procurement policy. All of the sponsored acts are now chaptered sections of the California Government Code.

BACKGROUND:

It has always been the mission of the United States Congress to oversight and advocate the needs and aspirations of those service persons our government has placed "in harms way". It has also been a special concern of the Congress to care and advocate for those subsequently maimed and tortured in service to our nation.

There are various legislative efforts to assist the Service Disabled and Prisoner of War Veteran (SDV) to enable his rehabilitation into society through the use of medical advances such as new prosthetics, new medications and new care techniques. However, those SDV that are attempting to enhance their rehabilitation by being owners and operators of smaller businesses are continuing to suffer discrimination from the federal government bureaucracy.

The U.S. Congress has previously passed several acts intended to assist and support the increased economic participation by SDV and other disabled persons in the economy of the United States of America. Some of these acts, such as the AMERICANS WITH DISABILITIES ACT (ADA) and the VETERANS ACT (VA) have been severely compromised by regulatory fiat and bureaucratic discrimination.

THE FINDINGS:

Although the U.S. Congress has legislated and the Executive branch has concurred, that "disabled persons, AS A GROUP, are to be considered socially, economically, educationally, and vocationally, disadvantaged" (PL 101-336), the federal bureaucracy refuses to accept that direction. It will not afford the service disabled veterans participation in procurement

THE ISSUE:

In all incidents of this discrimination, and in all of the aforementioned agencies, there exists similar policies based on a presumption by one federal agency -- The Small Business Administration (SBA). The various federal agencies, including the state and local agencies they financially assist, have all established policies that require that when contracting and procurement assistance to disadvantaged populations is to be provided, the agencies will follow the policy and practice of the SBA.

The SBA has determined that SDV are not eligible when deciding which disadvantaged population members are worthy of eligibility for participation in special programs. Those "presumed" to be worthy are members of specific ethnic groups, including ALIENS from countries that have recently killed, maimed and tortured over 1,000,000 American servicemen.

Agencies have been very diligent in the inclusion of such non-citizen aliens as beneficiaries in their programs for the disadvantaged, but have denied such inclusion to those citizen veterans maimed and tortured in the preservation of freedom for all people -- especially the citizens of this nation.

Additionally, the SBA has stated that SDV are not worthy of participation in such programs unless they will relive and relate, the horror, pain and misery of their injuries and torture to the "satisfaction" of a panel of SBA employees.

THIS IS AN OUTRAGE AND INSULT OF BARBARIC PROPORTIONS.

It is also a gross violation of the AMERICANS WITH DISABILITIES ACT. The ADA defines who is to be considered disabled and that such

programs directed to the disadvantaged population.

The U.S. Department of Transportation (DOT) has not only refused to allow SDV participation in direct federal programs for the disadvantaged, but has also interfered with the attempts by the State of California legislature to provide support for SDV in state programs. DOT has decreed that SDV are not eligible for participation in state programs that are federally assisted, in contradiction to specific state legislation that directs SDV participation.

The U.S. Department of Veterans Affairs (USDVA) has taken a similar course of action in its policies towards SDV by declining to assist SDV to participate in USDVA procurement programs. The USDVA contends that they lack the congressional authorization to assist those SDV veterans seeking to maintain their rehabilitation by operating businesses, even though these veterans are actually the sole reason for USDVA existence.

The U.S. General Services Administration has also stated, when rejecting the requests of SDV to participate in its' procurement assistance programs for the disadvantaged, that GSA regulatory interpretations do not permit SDV participation in such programs.

This experience of rejection has also been the case in the following agencies and federally supported organizations:

The U.S. Department of Commerce

The U.S. Department of Defense

Fannie Mae

The Resolution Trust Corporation

AND OTHERS

"disabled persons, as a group, are socially, economically, vocationally, and educationally disadvantaged" and therefore entitled to all the benefits legislated for such populations.

SUMMARY:

SDV are unique in that they are the products of the actions of the U.S. Congress and the U.S. Executive Branch and SDV have an absolute right to be vigorously advocated by those officials who sent them to be killed, maimed and tortured in the interests of this nation, its programs and its institutions.

ACTION:

SERVICE DISABLED AND PRISONER OF WAR VETERANS REQUIRE LEGISLATIVE OR PRESIDENTIAL EXECUTIVE ORDER ACTION THAT WILL MANDATE THAT SERVICE DISABLED VETERANS RECEIVE THE SAME ENTITLEMENTS AS ARE MADE AVAILABLE TO OTHER DISADVANTAGED PERSONS AND GROUPS.

OUR NATION IS PRESENTLY EXPERIENCING AN ECONOMIC "CRISIS" THAT REQUIRES THE PARTICIPATION, NOT EXCLUSION, OF ALL BUSINESS IN OUR NATION. THE SDV BUSINESS OWNERS OF THIS NATION HAVE PREVIOUSLY SACRIFICED TO PROTECT THIS NATION AND THEY ARE READY TO SERVE AGAIN.

I THANK YOU FOR YOUR ATTENTION AND I WILL TRY TO ANSWER ANY QUESTIONS THAT YOU MAY HAVE REGARDING MY TESTIMONY AND THE CONCERNS IT ADDRESSES. I HAVE ALSO APPENDED FURTHER INFORMATION FOR YOUR ATTENTION.

TESTIMONY OF KAREN JOHNSON
BEFORE THE U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
May 5, 1993

This testimony is presented in conjunction with the twelfth annual conference of The William Joiner Center for the Study of War and Social Consequences located at The University of Massachusetts, Boston Harbor Campus, on the subject of "Health Care, Economic Opportunities and Social Services--A Vietnam Era Veteran Perspective".

"FROM A WOMAN'S POINT OF VIEW"

The three areas of discussion identified in the title of this public hearing, while, at first blush appearing separate and distinct, in fact are all inter-related when observed from a woman veteran's point of view.

Without adequate access to basic health care, many Americans cannot long remain in the active work force due to injury, untreated illness which worsens without appropriate medical intervention, and chronic illness which incapacitates without treatment or medication. This problem is intensified for many women veterans who because of lower income cannot obtain or afford any health insurance, and depend upon the Department of Veterans' Affairs (DVA) Medical Centers (VAMC) for their primary health care.

Male and female veterans theoretically have equal access to Small Business Administration (SBA) loans to start their own businesses. However, in recognized profit industries like construction or technology-related industry, women historically are under-represented and usually have only had work experience in female-traditional service occupations. Because of the, now recognized, "Glass Ceiling" theory, many women have not risen to levels of management where they have gained enough experience to be a proven quantity in running their own business even in these traditional occupations, let alone starting a business in a non-traditional industry. This additional risk factor based on lack of experience in all phases of traditional businesses and little or no experience in some of the higher-paying non-traditional industries often times is the deciding factor in making a government-backed SBA loan.

While the SBA has done a good job in providing training for those veterans seeking to start their own business and in obtaining government contracts and 8A set-aside funds for small businesses, there is not one program specifically targeted for the female veteran to assist them in gaining the experience or training they need to start their own business, either in a traditional service industry or a non-traditional industry. Without this type of "catch-up" assistance, the ability of women veterans to take advantage of existing programs is less than equal when compared to their male veteran counterparts.

The DVA has no in-house program for providing direct or guaranteed loans for veterans in business, although some of these programs may be shifted from the SBA in the future. But, even when this shift occurs, the training deficit will remain. There is no "filing cabinet" plan to follow if the DVA, as no such program has ever been created by either the SBA or the DVA. The Department of Labor has some programs like the Disabled Veteran Outreach Program (DVOP) and Veterans' Training Program which have tailored some programs for the special developing needs of women veterans, but many of these programs are under-funded, and most are unknown to the women veteran population.

With the option of owning a small business diminished for women veterans, those with chronic illnesses, or disabled, must either find employment that can accommodate a liberal leave policy,

work part time, or exist on the amount of disability received. This further relegates them to dependence on the DVA for their medical care as they cannot afford health insurance when they are unemployed, not fully employed, and normally are not eligible if working part time.

The DVA is currently ill-equipped to care for the women veterans who now depend on the DVA for their primary care, let alone those who are eligible for care but are currently receiving care elsewhere utilizing private benefits.

As testimony before this Subcommittee today will point out, the DVA currently has only 23 mammography units in use at their 172 hospitals, with most of those having been installed within the last 24 months. The women who by economic necessity must depend on the DVA for their primary care cannot even receive a simple, basic, DVA-mandated, U.S. Surgeon General recommended, annual mammogram at most DVA medical centers, let alone bone density tests to prevent osteoporosis, and ultra-sound tests to find gynecological cysts which could be non-invasvically removed at early stages. These women are caught on a treadmill which leads them further into poverty and total dependence on the DVA for more and more costly medical procedures.

The women veterans who do have private insurance are certainly not inclined to use a DVA facility which has no equipment or personnel to care for their health needs. Without access to this larger female veteran population the DVA has a circular argument that there is no economic reason to cater to a few female veterans as that money is better spent to serve the needs of the thousands of male veterans. This practice perpetuates the status-quo. It also forces those female veterans dependent upon the DVA for their medical care to have a need for the DVA social services which are also woefully inadequate for female veterans.

DVA homeless programs and domiciliary programs have quotas for female veterans based on facilities set aside for their use and not on the female veteran population. Alcohol detoxification and Post-Traumatic Stress Disorder (PTSD) programs are similarly limited, and until recently no special treatment was designed for female veterans.

In short, the DVA has been a very inhospitable environment for female veterans for some time. Once that attitude has permeated throughout the DVA system, it is very difficult to change within the DVA. It may be even more difficult to change within the female veteran population who have either had a bad experience at a DVA medical center and vowed never to return, or simply never had any knowledge of the DVA services available because of their limited facilities.

W N Y VETERANS' HOUSING
COALITION, INC.

CONGRESSIONAL TESTIMONY

BEFORE

THE UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON VETERANS AFFAIRS

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

Submitted by:

FRANK J FALKOWSKI

CHIEF OPERATING OFFICER
WESTERN NEW YORK VETERAN'S HOUSING COALITION INC.

&

JOSE L. FUENTES CAC.

PROGRAM DIRECTOR
WNY VETERAN'S HOUSING COALITION INC.
MAYDAY HOUSE

MAY 5, 1993

1125 Main St., Suite 27 — Buffalo, New York 14209-2307
Phone (716) 885-8538 — Fax (716) 885-3073

Mr. Chairman and Members of the Committee:

On behalf of the Western New York Veterans Housing Coalition Inc., it gives me great pleasure and honor to submit the following testimony and to share with you our perspectives relative to the issue areas facing our client base of handicapped and homeless male and female veterans and their families.

In May of 1990, I had the privilege of speaking to this committee about the successes of our not-for-profit housing corporation in Buffalo to construct and renovate accessible and affordable housing for disabled and handicapped veterans of all wars. Recognizing housing needs and accessibility to needed services, we have been successful in breaking the cycle of homelessness and obtaining stability not only in housing but in physical and mental health. Starting with a vision, a $1500 grant from the United Way, and the donation of a four story building from the City of Buffalo, our organization began moving toward an aggressive housing initiative. To date we have a total of 36 permanent housing units, 20 homeless and transitional beds, and a Day Care Center located in our commercial space which provides services to low and moderate income families and single parents. We currently have in construction, a 24 unit complex for handicapped individuals, a 41 unit facility for low income and transitional housing, and a 9 unit demonstration project for the severely challenged individual.

Though we have been very successful in our housing development initiatives, we find ourselves faced with an increasing number of veterans who are homeless, economically displaced, or in need of health care and social services.

Our nations continued fiscal and health care crisis is impacting our ability to provide needed services in a progression that will lead to independent living.

Continued cuts in services and funding on all levels of government have exacerbated this problem. In order to become part of the solution instead of part of the problem, we have undertaken the responsibility of providing broad based support services, including nursing services where appropriate, shared aide programs, and a aggressive case management program. Visionary programs that provide resources and services for disabled and homeless veterans must be continually developed and implemented.

In conjuction with our development efforts, we have expanded our service component called Mayday House, to include a therapeutic community which acts as a "safety net" to assist the veteran in further development of relapse prevention. Our residents are assisted to develop and maintain strong individual and personal programs whether in recovery or not, in order to ensure on-going abstinence and achieve responsible, independent community living. Often we see veterans fall through the cracks because of a lack of adequate housing and services thus making relapse inevitable for many and contributing to the revolving door dilemma that plagues many service providers.

It is not uncommon to find veterans stranded in VA Hospital wards because they cannot access affordable and accessible housing or do not have the financial where with all to afford home health care or case management services which if available would allow them to live independently.

Escalating per diem costs associated with hospital health care necessitate maximizing out-patient services in order to be cost effective and save public dollars.

I am sure that many of my associates will agree that shelter and non-housing services for homeless and disabled veterans are scarce. The services that are available are short term and inadequate for veterans with disabilities, particularly veterans with needs for accessible housing, attendant services, and social work support. The lack of housing and services forces many veterans to live in non-accessible housing or to remain in institutional settings.

Lastly, it is going to require additional federal and state government long term commitment to support and finance cost effective housing programs that afford the veteran the opportunity to live independently rather that utilizing hospitals or nursing homes at costs that for most are prohibitive. Collaborative efforts and solutions must continue. Government programs alone do not have the resources necessary to remove all the obstacles that homeless and disabled veterans face. By formulating partnerships with other members of the community much more can be accomplished.

Mr. Chairman, we remain optimistic that with continued support from all levels of government and with continued private sector initiatives, we can eliminate the band aid approaches of the past. I thank you for holding this hearing and your support for the Annual Conference on the Concerns of Veterans is greatly appreciated. Our participation over the years has provided us with valuable resources and has contributed greatly in the networking of information to those of us in the trenches.

Mayday House
A Program Of
WNY Veterans' Housing
Coalition

Mayday House is a temporary residential treatment program for homeless veterans. We are part of WNY Veterans' Housing Coalition. A non-profit Corporation that rehabilitates and builds low-cost housing for veterans and other persons with disabilities.

The goal of our program is to help veterans with problems that need to be addressed in order for them to achieve independent living. We have a full-time staff that work as case managers who help the residents help themselves. We are not a halfway house, but we do provide a clean and sober environment for the residents. Most of the residents are in recovery from drug or alcohol dependence along with other secondary diagnosis, such as PTSD. We strongly believe that our residents need to participate in out-patient counseling that address their individual needs along with the added support of A.A. and N.A. meetings in the community.

We believe that the veteran needs to work on his whole life rather than just his recovery. We give assistance in activities of daily living, food preparation, employment counseling, vocational assistance through VISID, Veterans Benefits counseling, evaluation of their homeless problem through the VA Homeless Program, housing and Section 8 assistance through R.A.C. and Belmont Shelter, legal referral through Legal Aid and independent counsel, aftercare through the Downtown Clinic, VA ASAP and any other service provider that may be needed to help our residents in achieving independent living. It is our primary goal to have our residents learn to take responsibility for themselves and at the same time become a part of their community. Veterans that are admitted into this program are expected to comply with all rules and regulations that are necessary to ensure an alcohol- and drug-free environment. Some of our rules include drug and alcohol screening and mandatory curfews.

Mayday House has two components that allow us to work with our residents for up to one and one-half years. We provide a 4-month period in which residents must seek employment or secure benefits that will aid them in achieving independent living.

Once a person completes this 4-month preparation for independent living, we provide, if possible, an apartment in one of our development sites. Residents must agree to continue in an aftercare activity and agree to be randomly tested for alcohol and drugs by Mayday House staff. We continue to be supportive and do follow-up case management for one full year. All veterans are evaluated by Mayday House staff and the HCMI program of the VA Medical Center to determine need.

We are limited in bed availability and currently have a population of 12 residents in phase one and 10 residents in phase two. It is our hope that we can increase the number of veterans that we help during the coming year.

If you have any need for additional information, please feel free to call us at **(716) 882-5935**.

The Buffalo News/Friday, January 8, 1993

State housing grants to aid homeless here

By AGNES PALAZZETTI
News Staff Reporter

Housing projects for homeless people received the go-ahead this week with the announcement of more than $1 million in state grants to two local agencies.

When the projects, which will total $2 million, are completed, 18 to 21 families will have houses, and nine physically disabled veterans will have apartments.

Gov. Cuomo announced a $22 million statewide housing program that includes a $560,000 grant to the Community Action Organization and a $483,000 grant to the Western New York Veterans Housing Coalition.

Each organization has assurances of roughly another $500,000 in grants from federal housing money and the state Department of Social Services.

Florence Baugh, director of the CAO Neighborhood Services Department, said the agency is negotiating with the city to purchase structurally sound homes the city has foreclosed on or will be foreclosing on because of overdue taxes.

"They have to be homes that only need a moderate amount of rehabilitation," Mrs. Baugh explained, "because we want to stretch the money as far as we can. Once they have been restored, they will be rented to families who are now in shelters or to families facing eviction."

The CAO has completed rehabilitation of 11 duplex structures and construction of 11 new homes for homeless families.

The core of the apartment complex for the disabled veterans will be the former Engine 16 fire hall on Main Street near West Utica Street.

The apartments are designed for physically disabled veterans now living in hospitals or nursing homes "simply because there is no housing available to them," said Frank Falkowski, director of the Veterans Housing Coalition.

"While they may seem expensive to build, they are actually cost-effective when you remember that hospitals and nursing homes can cost up to $400 a day," he said.

Edward Steinfeld, a professor at the University at Buffalo School of Architecture, is the project architect.

C
Saturday, February 6, 1993
THE BUFFALO NEWS
Local News

Disabled man helps to spark special housing

Experiment could focus national spotlight on city

By DICK CHRISTIAN
News Staff Reporter

The determination of one man and the support of many others will result this year in the realization of a long overdue project. It also may complete an experiment that could focus national attention on the City of Buffalo.

Jamie Lembeck, following spinal surgery and a subsequent fall, became a quadraparetic in 1985. He suffered permanent spinal damage and is unable to use his arms and legs.

By 1990, he had made up his mind to do something about the lack of affordable and, more important, "fully accessible" housing for the disabled.

"I did not look at this as some kind of a cause," said Lembeck, 39. "It was a personal thing. I was living in a small private house but had great difficulty in getting in and out without assistance. I lived there before I was disabled, and I suddenly felt I had totally lost my sense of independence."

He called a friend, Gary Rogers, in December 1990, and asked for help. Rogers is director of revitalization for the city.

What did he need, Rogers asked?

A building that could be made barrier-free and adaptable to provide the maximum of independence for residents in wheelchairs.

"Eventually we found the old Engine 16 Firehouse on Main Street near West Utica that had been closed for years," Lembeck said. "It was built in 1884 and is the right size and location for what we want to do. The city wasn't receiving any income from it. It is right across the street from Metro Rail's Utica station, is near shopping areas and, all in all, was just what we were looking for."

With the help of Rogers and Delaware Council Member Alfred T. Coppola, the Western New York Veterans' Housing Coalition sponsored the project in order to obtain funds.

The coalition will receive about $320,000 from the Federal HOME agency, $480,000 from the State Homeless Housing Assistance Program, $80,000 from a Buffalo Community Development block grant, and $50,000 from the State Department of Social Services.

"We're looking at a $900,000 project," Lembeck said; "but it's going to be well worth it."

In addition, the Veterans' Housing Coalition also agreed to be a sponsoring agency for the project, said Frank Falkowski, director of the coalition.

ROBERT L. SMITH/Buffalo News

Looking over plans for housing for disabled are, from left, Al O'Brien, the contractor, UB Professor Edward Steinfeld and Jamie Lembeck, an advocate for the disabled.

"We'll acquire the Engine 16 building from the City of Buffalo, demolish the rear portion of the building, and construct nine units of fully accessible housing for homeless disabled individuals. The firehouse itself will be rehabilitated to accommodate three units and six new units will be constructed in the rear."

Edward Steinfeld, a professor in the University of Buffalo's department of architecture, has provided his services as a consultant to the project's architectural firm, Trautman Associates in Buffalo.

"This is a very exciting project and it will probably draw national attention to the way the project is developed and the technology that is used in construction of the project," Steinfeld said.

He said the Center for Therapeutic Applications of Technology and similar organizations across the country look at Lembeck's project as "a demonstration project, especially in developing new assistive approaches in technology for independent living." Information gathered from this program, he says, may make the Engine 16 building a standard for developing accessible handicapped housing in the future.

Construction is expected to start at the end of April, said Al O'Brien, president of Teleo Construction of Buffalo.

"We're going to preserve the face of the building that identifies it as the old Engine 16 Firehouse, but the interior construction and the technology that goes into it will be state of the art."

Testimony of W. Norman Johnson, Rear Admiral, USN (ret.)
Vice President and Dean of Students, Boston University
before
The Subcommittee on Oversight and Investigations
House Committee on Veterans' Affairs

May 5, 1993

Since my testimony before the subcommittee on September 23, 1992, a great deal has transpired in the First in Peace program. To refresh your memories, First in Peace is a program at Boston University that will employ young veterans as mentors and educators for inner-city adolescents who are wards of the state or homeless. Our veteran cadre will live with the youth participants in military housing and have access to other recreational and educational facilities at closed or closing military bases. In addition, the veterans will accompany these young people to their inner-city schools daily, serving as teacher's aides, security personnel, or in any other roles the principals decide can best support the school's mission.

After a great deal of publicity in the media and numerous speaking engagements, First in Peace received the attention of the White House, and the Office of National Service. In essence, we have traveled from an idea in September, 1992, to a comprehensive operation proposal with a prospective client: the federal government.

Accordingly, at the request of the White House in March 1993, I presented the First in Peace concept to a group consisting of representatives of the Office of National Service, the Office of Veterans Affairs, the Joint Chiefs of Staff, the Commission of National and Community Service, the National Guard, and staffers from the offices of Senators Boren and Wofford, the legislators who sponsored the Civilian Community Corps legislation. The Office of National Service hoped to fund Boston University's prototype under the demonstration rubric of the CCC legislation. That prototype would engage veterans and inner-city youth, ages 14-18, in residence on closing bases near Boston. The Boston University model would provide jobs for 25 veterans and 100 students at Ft. Devens. The model has an educational component for the students consisting of 160 hours: 90 in classes on reading, math, life skills, and career choices. They will also spend 60 hours engaged in community service, much of which has a strong apprenticeship component that could lead to employment.

Veterans would also receive 75 hours of classroom education which would include resume writing, career choices, and computer skills such as spread sheets, data base management, and the like. Supplemental lectures from Boston University faculty and staff would provide information on selected topics of interest to veterans with implications for higher education and career transition employment opportunities. Two weeks of extensive evaluation to measure the eight-week program's effectiveness would document lessons learned.

Despite genuine enthusiasm for the proposal, the National Service Office could not go forward with the demonstration for the reasons cited in this letter written by Director Eli Segal:

THE WHITE HOUSE
WASHINGTON
April 16, 1993

Dean W. Norman Johnson
Vice President and Dean of Students
Boston University
775 Commonwealth
Boston, MA 02215

Dear Dean Johnson:

I am writing on behalf of all of us who had the opportunity to review the outstanding proposal you submitted for a Civilian Community Corps (CCC) demonstration program using military facilities on the base closure list as a residential site and military veterans as the supervising cadre for a service oriented program targeting disadvantaged youth. Unfortunately, specific legal

obstacles prevented the Commission on National and Community Service from being able to sole-source a CCC summer demonstration project.

However, everyone in my office and at the Commission who looked at your First in Peace effort and your summer proposal readily recognized the potential, conceptual integrity and programmatic efficiency of both concepts. These concepts underscore the tremendous effort you have put into serving your community, and I hope that as we move forward in developing and designing the CCC program, we can call on your expertise and advice.

I wish you well in your efforts to realize First in Peace and hope that we can continue our dialogue on the best ways to reach out to our communities and make for a better America. Thanks again.

Sincerely,

Eli J. Segal
Assistant to the President
and Director, Office of
National Service

That setback notwithstanding, the First in Peace model has considerable momentum, and it would be negligence on the part of the University and the nation's leaders to let it slip away. I intend to bring the proposal to the attention of the many foundations, businesses, and individuals who have already corresponded with me indicating their willingness to help fund such an effort. With this private support, we still hope to test the model and its potential to provide the necessary jobs, education, and improved quality of life for both veterans and students. We also plan to demonstrate that this model can do all those things at a significantly lower cost than any of the competing alternatives. It is worth noting that the jobs in the recently killed $6 billion presidential economic stimulation program, which also had a summer jobs component, would have cost $89,000 *per individual*, whereas Boston University's First in Peace program would do the same thing for $3,900 per individual, or 4.4% of the government's projected cost per person! This economy alone makes the effort worth pursuing, and it is on that basis we are seeking this Committee's continued and vocal support.

Frankly, given the administrative logjam that seems to characterize so much of the current bureaucratic environment, substantive forward movement through the offices of any of the obvious agencies we might ordinarily turn to for support seems highly unlikely indeed. Clearly the Department of Veterans Affairs has its own agenda. The Director of Veterans Assistance Service recently sent me this interesting observation:

> As you may know, VA is involved in several initiatives to assist active duty military personnel in their transition to the civilian sector following their release from the armed forces. VA is a partner agency with the Department of Labor (DoL) and the Department of Defense (DoD) in the Transition Assistance Program (TAP).
>
> In addition, the Service Members Occupational Conversion and Training Act of 1992, will be implemented in the very near future. This program is designed to assist veterans through a job training program developed by private employers. The program is being implemented jointly by DoD, DoL, and VA.
>
> Your proposal does have merit but does not directly correlate with any of the programs described above. Further, I do not believe that your proposal falls within the purview of VA.

Perhaps it does not. My distinct sense in any case is that the VA has its own agenda, and so do the other agencies with similar interests. Recent history has shown us, however, that the efficacy of that agenda remains somewhat in doubt. If the things already in place <u>are not</u> moving, it seems a shame that something that <u>can</u> move has not found its place. This Committee could help it do that, and I sincerely hope that all of you will give more than a little thought to seeing to it that it does.

Thank you! Are there any questions?

Puerto Rican Veteran's Association of Mass, Inc.
2595 Main Street, P.O. Box 70185
Springfield, MA 01107
(413) 731-0194

Gumersindo Gomez
Executive Director

Sergio Kantieh
President

April 26, 1993

U.S. House of Representative
Committee on Veterans' Affairs
333 Cannon House Office Building
Washington, D.C. 20515

Re: The need to provide opportunity for Small Business to Hispanic Veterans.

On behalf of the Board of Directors of the Puerto Rican Veterans Association of Mass., Inc. and the Puerto Rican Veterans of Massachusetts, we thank you for giving us the opportunity to do this presentation.

Because of the unemployment rate within the area that we serve our veterans, which is contemplated as one of the highest in Western Massachusetts, it is important to render the chance for Small Business to Hispanic Veterans. This will give them the opportunity to institute their own businesses. With this establishment of businesses, they will be able to hire other veterans in their particular businesses.

We affirm very strongly, that the economy of this country will be helped with small business in the community and the hiring of community people to work in these comparable businesses. Since 1987 the effects of the economy in America has been painful and profound. More than 6 million permanent pink slips have been handed out, and layoffs are occurring at an even faster pace this year than in 1992. Despite signs of a brisker economy, at least 87 large firms announced major job cuts in the first two months of 1993 alone.

But, for our Hispanic Veterans, the established Small Business Offices located throughout the region, that is not the answer. Why? The lack of bilingual/bicultural personnel in these offices detract the sensitiveness and reassurance that our veterans need to go through a process that is cut up in red tape.

The way to go, so our Hispanic Veterans will have a chance in the system, is through established agencies in the region that work with our community and that can render the type of guidance they need to achieve successfulness in their business plan.

One of these agencies is Brightwood Development Corporation in Springfield, Massachusetts. Us, the Puerto Rican Veterans Association in conjunction with Brightwood Development Corporation have been successful in establishing two small businesses with veterans in the last year and we are currently working with two others and it looks positive for them.

In conclusion, we ask that this Committee take in consideration ways in which financial aid, from the small businesses administration find its way to the different community agencies that work with the Hispanic Veterans and his family, in order that our veterans get a chance to enter the small business world.

Respectfully,

Gumersindo Gomez
Executive Director

GG/wm

Swords To Plowshares
a veterans' rights organization

400 Valencia Street
San Francisco, CA 94103

Telephone
(415) 552-8804

May 1, 1993

DELIVERING COST EFFECTIVE SERVICES TO HOMELESS VETERANS

The Problem

- There is a crisis of homelessness among veterans. Veterans make up over 30% of the homeless population nationwide--250,000 veterans are homeless on any given night.
- Since the VA received initial McKinney funds for its homeless program in 1987, they have not increased the funding for residential care for homeless veterans.
- Under the new administration, the VA has sought additional monies for homeless services. Unfortunately, proposed VA services duplicate existing programs in some areas, while neglecting other communities which lack veteran-specific services. The proposed expansion does not increase the number of crucial residential program placements.
- The VA's medical model for service delivery inflates the costs of homeless services.

The Solutions

- Homeless veterans need residential care and transitional programs above all other services.
- The severity of this crisis and the scarcity of resources mandate that public and private providers work and plan together to create the best possible programs.
- Community-based, veteran-specific agencies can play a vital role in helping the VA meet its mission of serving veterans. These providers are more responsive and cost effective. Non-profit agencies can leverage an innovative array of public and private resources, not available to government institutions.

Swords to Plowshares' Experience

Since 1974, Swords to Plowshares has been providing a full range of services to veterans in San Francisco, including employment and training, counseling, legal advocacy and housing programs.

In 1988, the VA contracted with Swords' residential transitional program. In the five years of its operation, the VA drastically reduced referrals to Swords' program--from 15 in 1988 to 6 today. This reduction has threatened the very existence of our program--without a

predictable revenue base a stable facility and staff are jeopardized. There are an estimated 2,500 homeless veterans in San Francisco–and only 6 placed in the sole veteran-specific residential program.

Most recently, the VA has announced that they are opening a drop-in center for homeless services *three blocks* from Swords' own multi-service center. The funding that supports this expansion was obtained through HR5400–legislation that was initially inspired by the testimony of the National Coalition for Homeless Veterans, of which Swords is a founding member. The original version of the bill required that the VA *contract out* to community providers and that the VA *not duplicate* services already being provided by these agencies.

While the VA contends that the new center will increase services to homeless veterans, existing, more cost-effective programs are threatened by this duplication of services. The VA's homeless case management program has been doubled while critical residential treatment and housing have been halved. Communities within the VA's regional jurisdiction that do not have the benefit of veteran-specific, community-based providers remain without services.

Had the community been a part of the planning process, the VA funds would have been maximized–an effective collaboration would have led to increased residential program slots and an expanded area served.

Conclusions

To make the best use of precious resources, the VA should:

- contract and collaborate with community agencies who are already working with homeless veterans, especially residential programs;

- not duplicate existing services and not neglect regional responsibility to under-served areas.

To these ends, we recommend:

- The establishment of a VA Assistant Secretaryship for Community-based Services. In order to form true partnerships local needs and local resources must be taken into consideration on a case by case basis.

- The presentation of a full cost benefit analysis of the new homeless services, funded by the $10 million allocation from HR5400.

Everyone serving this population welcomes the new resources that the VA is bringing to the crisis of homelessness among veterans. But, a new approach to service delivery must accompany these monies. ***Community-based, residential care programs are the most cost effective means to transition homeless veterans to self sufficiency.***

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN

SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS AFFAIRS

VETERANS HEALTH CARE, ECONOMIC OPPORTUNITIES AND SOCIAL SERVICES
FOR VETERANS & THEIR DEPENDENTS - A COMMUNITY PERSPECTIVE
MAY 5, 1993

ANSWERS SUBMITTED BY DR. V. SUZANNE KLIMBERG
CHIEF OF BREAST SERVICE
SURGICAL ONCOLOGY, UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES
ARKANSAS CANCER RESEARCH CENTER
CHIEF OF WOMEN'S ONCOLOGY
JOHN L. MC CLELLAN MEMORIAL VETERANS MEDICAL CENTER

QUESTION: Is it conclusively known that women veterans have a higher incidence of cancer than their non-veteran peers or is research needed to answer this question?

ANSWER: I do not believe it is conclusively known that women veterans have a higher incidence of cancer, however, many small studies indicate that this is the case.

QUESTION: What information is available today to answer this question and what does this information suggest or indicate?

ANSWER: The 1985 VA survey of "all female veterans" showed nearly twice the rate of cancer as that in the general United States population. However, as you know this can't have possibly included "all female veterans" since they are not known. The Bay Pines Study included only 115 female veterans and showed a 50% increase in cancer rate. Han Kang, Ph.D., Director of the VA Environmental Epidemiology Service, recently conducted a mortality study which concluded that female veterans had 2.5 times the expected number of deaths from pancreatic cancer and three times the number of deaths secondary to cancer of the uterus.

QUESTION: If research is needed, what type of research should be conducted, how much would it cost, how long would it take to conduct?

ANSWER: Dr. Kang would be a good person to testify (or talk with) since he has a new pilot trial approved to determine the feasibility of conducting a full study, and he could give you a better idea of how long and how much it would cost to complete the nationwide network study of veterans needed to answer this most important question.

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN

SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS AFFAIRS

VETERANS HEALTH CARE, ECONOMIC OPPORTUNITIES AND SOCIAL SERVICES
FOR VETERANS & THEIR DEPENDENTS - A COMMUNITY PERSPECTIVE
MAY 5, 1993

QUESTIONS FOR MR. JEFF TEPSITCH
HIV/AIDS PROGRAM COORDINATOR
BOSTON, MA VA MEDICAL CENTER

Your testimony noted VA is providing health care to two groups of HIV positive veterans - service-connected veterans and veterans with wartime service who receive a VA pension.

Question:

Is VA health care for HIV positive veterans restricted to service-connected veterans and veterans who receive a VA pension?

Answer:

VA health care for HIV positive veterans is not restricted to service-connected veterans or veterans who receive a VA pension. VA health care for HIV positive veterans is provided to all honorably discharged veterans regardless of their service-connected status or ability to pay for services. Veterans who are service connected for this disease are provided with free care and free HIV related medications. Veterans who are not service connected for this disease may have to make a co-payment for each clinic visit providing their monthly income exceeds guidelines established by the Department of Veterans Affairs. Veterans who are non-service connected for this disease are charged a $2.00 co-payment for each thirty (30) day supply of HIV related medications. If the veteran is non-service connected and has private insurance, their insurance company will also be billed for all medical appointments.

Question:

Does VA provide health care to HIV positive veterans who are not either service-connected or in receipt of a VA pension?

Answer:

The VA provides HIV care to all honorably discharged veterans regardless of whether they are service-connected for this disease or in receipt of a VA pension.

Response to Follow-up Question
on Testimony Presented by Gary E. May

**Before the Subcommittee on Oversight and Investigations
of the House Veterans Affairs Committee
May 5th, 1993**

Question: ""Your testimony emphasized social service needs of Vietnam veterans and their families, especially veterans who have children with a disability. What role should VA play in providing social services to veteran and their families?"

Answer:

In my testimony, I made three points which can be brought to bear in answer to the question you pose. First, I recommended that services should be better coordinated and integrated at the Federal, State and Local level, and not only within the realm of veterans services or the VA, but among other human service agencies and the VA.

Vietnam veterans (or any veteran for that matter) often have needs themselves which can be addressed more effectively through a coordinated approach which encompasses services beyond the range available though the traditional veterans services world. When the veteran has a family, particularly a family which includes a child with a disability, and approaches a veterans' service provider, as a first resource, he or she runs a very high risk of ending up in a cul-de-sac consisting of agencies and well-meaning human services providers who are not even aware of the wealth of resources available to deal with family-related needs. The isolation of the world of veterans' services which is at the root of this phenomenon can only be addressed through intensive training and a bit of reorganization. Social work professionals and counselors, particularly those who work in the Vet Center program or in VAMCs, should be trained in a broad range of modern human services, not so that they can take on new service responsibilities, but so they at least know what is out there to meet the needs of their clients. Part of that training should involve modern service-coordination or case-management so that informed and appropriate referrals can be made to other service providers who are equipped to address family or children's health needs.

The Agent Orange Class Assistance Program has funded a number of Vietnam veterans community-based organizations and even traditional veterans service organizations who have had hardly even passing experience in dealing with family service issues, and no prior experience in dealing with the needs of families with children with disabilities. AOCAP has nevertheless required each and every grantee to deal with such needs and to perform their overall program responsibilities from within a family service orientation. In order to provide the necessary back-up consulting expertise for these programs lacking in experience with children's disabilities issues, AOCAP funds a central "clearinghouse" program. This project, the National Information System for Vietnam Veterans and Their Families (NIS), operates as part information and referral

service and part resource broker for families as well as other AOCAP projects. The NIS has 15 highly trained disabilities "Information Specialists" on staff who can be reached through a toll-free telephone line and who have an automated database of over 100,000 disabilities service providers at their fingertips which can be cross-referenced geographically to match services needed in the local area of a grantee project or client. Such a system could easily be adapted as a resource for Vet Center personnel or VAMC social workers.

Another point I made in my written testimony is that there is a valuable resource to be found in the network of community based service providers around the country who have already been providing integrated family services for decades and many of whom have the experience and abilities to provide counseling to Vietnam and other veterans as effectively as Vet Centers. Much more consideration should be given to contracting out many services currently provided by the VA through these "CBOs". A case can be made that the delivery of counseling services through these community-based organizations is even more cost-effective than Vet Centers as well, but the critical strengths in this service delivery model is that CBOs are well integrated into a community network of services and their strengths, by and large, are in the family service area.

Above all other considerations, the VA and other related veterans service agencies should adopt, at least in larger part, a family service orientation. Family oriented service models and approaches are now the norm in modern human services, and it is difficult to communicate or integrate services with agencies who operate within such a model without at least understanding it. Aside from the mere fact that family service is the new norm, it has been clearly demonstrated through the AOCAP program experience that such an approach is more effective in dealing with Vietnam veterans needs than the traditional individual veteran-directed model. Although there has been some development of family service components in the Vet Center program since Desert Storm, the VA system as a whole is still single veteran-focused and entitlement driven. As a matter of fact, the current state of veteran related services is such at the present time that the Military branches have much more of a family focus in social services than the VA.

National Center for Post Traumatic Stress Disorder
Clinical Laboratory and Education Division
VAMC
3801 Miranda Avenue
Palo Alto, California 33504
June 10, 1993

Honorable Lane Evans, Chairman
Subcommittee on Oversight & Investigation
Committee on Veterans Affairs
U.S. House of Representatives
335 Cannon House Office Building
Washington DC 20515

regarding: Response to question submitted to me following my testimony before the subcommittee during its hearings on May 5, 1993 on Veterans Health Care, Economic Opportunities and Social Services for Veterans and Their Dependents - A Community Perspective.

Question:
Funds previously made availavble to the National Center for PTSD are reportedly being reallocated to support the newly established Women's Health Science Division; no new funding is being provided to the women's Health Science Division.

How much support is being provided for the Women's Health Science Division?

The Executive Board of the National Center allocated $400,000 to support research and educational programs related to Post-Traumatic Stress Disorder among female veterans. $350,000 of that is being used to establish and support the research activities at the National Center's Women's Health Sciences Division in Boston. $50,000 is designated for support of educational initiatives originating from the Clinical Laboratory and Education Division in Palo Alto, California.

Please identify the other initiatives from which these funds are being reallocated to the Women's Health Science Division?

The U.S. Congress authorized a budget supplement of 1.5 million dollars to the Department of Veteran's Affairs National Center Post Traumatic Stress Disorder to support its ongoing Research and Education activities . These activities are detailed in the National Centers' Annual reports, copies of which are available through the administrative division located at the VAMC in White River Junction, Vermont. The reponsibilities of the National Center expand yearly and demands for its involvement in national training and research initiatives have increased significantly since its inception. In making the decision to support the creation of the Women's Divsion, the Executive Board of the Center reduced the supplement to the other divisions, thus reducing support for the many expanding programs throughout the National Center.

Respectfully submitted,

Joan A. Furey, RN, MA

THE VIETNAM VETERANS WORKSHOP, BOSTON

New England Shelter for Homeless Veterans

17 Court Street
Boston, Massachusetts 02108
(617) 248-9400
FAX (617) 248-0958

July 27, 1993

Representative Lane Evans
Committee on Veterans' Affairs
U.S. House of Representatives
335 Cannon House Office Building
Washington, D.C. 20515

Dear Congressman Evans:

I must first apologize for not answering your request in a more timely fashion. As Director of Operations at the Shelter, I manage to keep myself very busy, and often find myself working day and night. I am also very sure that you keep yourself busy as well.

I first became aware of the "Bad Paper" plight of the many veterans who were welcome at our Shelter, yet they were not welcome at the Veterans Administration about February 1989. I began to help these vets upgrade their discharges some three years ago. I had not idea of the scope this problem covered, and I'm only talking about the Community within Boston. Recently I have been contacted by people from outside our community, i.e. Detroit, Atlanta, Washington, D.C. and also from Congresswoman Waters who's constituents in Los Angeles, California have asked her to look into what can be done. I admit the information I can give you over the first two years is mostly guess work as I did not monitor or document the outcome. I, however, am sure that the number of cases handled was approximately 50 with a margin of error plus or minus 5.

In the past year we have processed approximately 25 cases through the Shelter Legal Services Foundation, that have been documented. This figure does not include approximately 5 cases that are waiting to be turned over to the Shelter Legal Services. I also anticipate this number to increase by 150% during the next year. More and more veterans with "bad paper" are becoming aware of the services available to them.

On more than one occasion, during my staff meetings, I have expressed to my staff the importance of finding resources for these

veterans' who cannot access the V.A. Hospitals and Outpatient Clinics. I will estimate that more then 50% of the veterans' who show up at our front door, are in need of immediate care and sometimes require immediate hospitalization. The number of veterans' that need a detoxification center is staggering. Those men who are not VA eligible have to be admitted to a private facility. It is our job to find the resources for payment of these treatments. A certain number of these cases are covered by free care, but I find it unconscionable that they need to apply for free care in the first place.

If you have any questions or comments, please feel free to contact me at the above address or telephone number.

Sincerely,

Warren T. Quinlan
Director
Shelter Operations

WTQ/dam

ASDV ASSOCIATION FOR SERVICE DISABLED VETERANS
P.O. Box 2312 · Stanford, CA · 94305 · (415) 949-3751 · *Fax 949-0336*

Honorable Lane Evans
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans Affairs
Washington, D.C.

Dear Mr. Evans:

Thank you for your request for additional information regarding the "Unwillingness of the U.S. Department of Veterans Affairs (USDVA) to assist service connected veterans in participating in USDVA procurements."

That information is attached.

Thank you for your courtesy and attention in allowing ASDV testimony and for your concern and consideration for the needs and aspirations of service disabled veterans.

Sincerely,

John K. Lopez, SDV
Chairman, ASDV

enclosure

ASDV ASSOCIATION FOR SERVICE DISABLED VETERANS
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"LACK OF ASSISTANCE TO SERVICE DISABLED VETERANS (SDV) OR VETERANS AFFAIRS (USDVA) WHEN CONSIDERING PARTICIPATION IN USDVA PROCUREMENT PROGRAMS"

ACTION POLICY:

The attached memo "Veteran Owned Small Business Outreach Program" is a summary of the "misinformation" that USDVA issues for regulatory compliance.

(1) VA acquisition personnel do little outreach of SDV, a survey of 28 service disabled veteran owned businesses (SDVB) in California indicates that none (0) have ever been contacted by USDVA for procurement opportunities. Although eleven (11) of twelve (12) minority and women owned businesses reported that they had been solicited by USDVA contracting officials. As indicated in the memo, when challenged to explain why SDVE are not similarly contacted, USDV officials respond that "the USDVA does not have authority to target or set aside acquisition, except for women and minority owned firms.

(2) Another response to inquiries made to the USDVA is "that all acquisitions are competitive, except for U.S. Small Business Administration (SBA) 8a procurements, the USDVA has no authority to give special consideration to veterans."

(3) The SBA and USDVA also respond that they do not offer acquisition related loans to SDVB. However, the referenced SBA and the U.S. Department of Transportation (DOT) reports that they will provide such loans to minorities and women.

(4) The SBA "special consideration" offered to veterans is notorious nationwide for the fact that it consists of nothing more than placing a veterans inquiry on the "top of the pile" for the inquiry date.

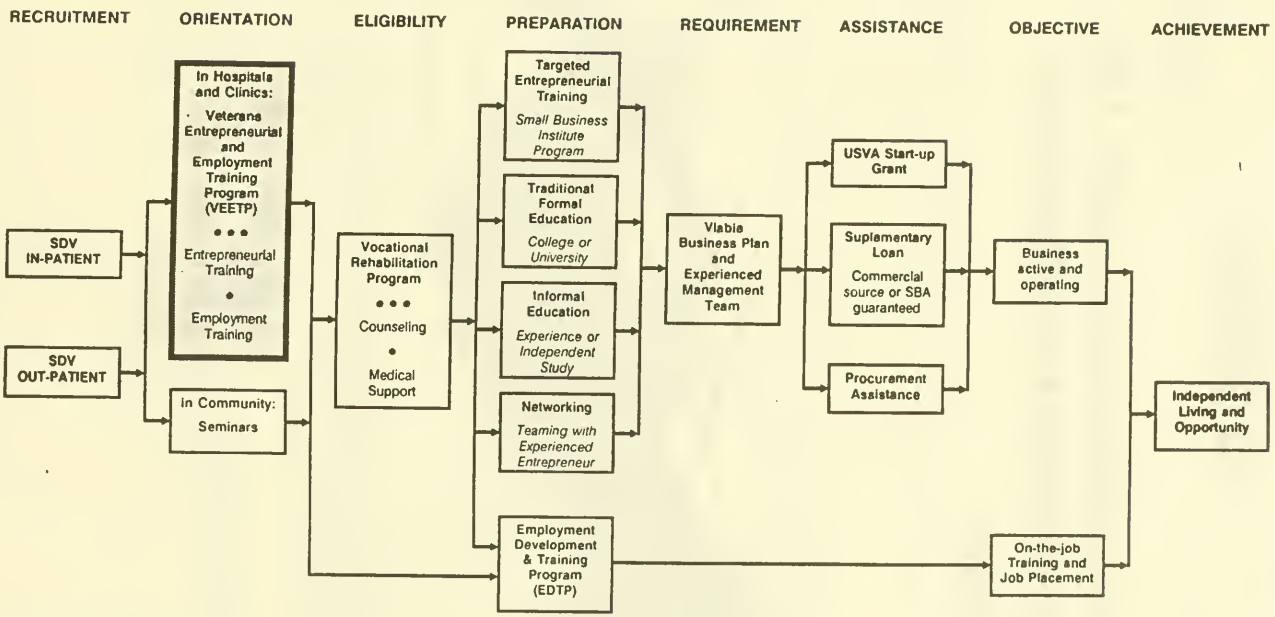
(5) As indicated, the USDVA focus is on "disadvantaged businesses, as designated by SBA, labor surplus area and women owned businesses." As indicated in USDVA literature, USDVA has specific set-aside procedures, negotiations and goals for those businesses. SDVB are only "encouraged to participate (6)" in the USDVA acquisition program.

POLICY STATEMENT:

On May 14, 1993 in a meeting to verify and define these directions and policies, a delegation of 18 SDVB met with Mr. Gary Krump, Acting Undersecretary for Acquisition and Facilities, USDVA.

Mr. Krump confirmed our interpretation of the aforementioned policies and repeatedly stressed that the USDVA will not take any action to enhance USDVA procurement opportunities for SDVE without legislated direction to do so. Mr. Krump also stressed to the delegation that the USDVA is guided in its procurement policies by the Federal Acquisition Regulations (FAR) and not by the needs and aspirations of service disabled veterans.

THE SDVI DEVELOPMENT PROGRAM



March 18, 1988

Department of
Veterans Affairs

Doing Business with the Department of Veterans Affairs

Office of Acquisition and
Materiel Management
Washington DC

Office of Small
& Disadvantaged Business
Utilization

Washington DC 20420

Department of
Veterans Affairs

In Reply Refer to:

VETERAN-OWNED SMALL BUSINESS OUTREACH PROGRAM

PROGRAM AUTHORITY: Legislative Intent P.L. 93-237

PURPOSE: To include veteran-owned small businesses (VOB) in the U.S. Department of Veterans Affairs (VA) acquisition program.

CAN ACQUISITIONS BE SET ASIDE FOR VETERAN-OWNED FIRMS?

(1) VA acquisition personnel are required to identify, assist, and include VOBs in VA acquisition opportunities, however, (3) VA does not have the authority to set aside acquisitions for VOBs. Veteran-owned firms should complete and submit a Standard Form 129, Solicitation Mailing list Application, to each VA acquisition facility.

HOW AND WHAT VA BUYS?

VA procurements are, for the most part, conducted on a decentralized basis. It is therefore, necessary for firms to contact VA facilities in the area in which they do business. OSDBU maintains a listing of names and telephone numbers of the Chiefs, Acquisition and Materiel Management and Purchasing. These individuals are responsible for the acquisition of goods and services at their facilities. (2) Contracts are generally awarded on a competitive or negotiated fixed price basis. VA buys annually over $4 billion in pharmaceuticals, medical and laboratory supplies and equipment, perishable subsistence, maintenance and repair of medical scientific equipment, prosthetic and orthopedic aids, ADP software and hardware, architect engineering services and building construction, maintenance and repair.

DOES VA PROVIDE BUSINESS LOANS?

VA does not provide business loans, but may provide self-employment assistance to qualified disabled veterans as an appropriate rehabilitation objective. However, the SBA does have a Veterans Business Program which is responsible (4) for giving "special consideration" to veterans in all its programs, including financial assistance. Contact the SBA Veterans Affairs Officer at your local SBA office which is listed under "United States Government" in most local telephone directories.

For additional information, contact the U.S. Department of Veterans Affairs, Office of Small and Disadvantaged Business Utilization (OSDBU) (005SB), 810 Vermont Avenue, NW, Washington, DC 20420, (202) 376-6996.

SMALL BUSINESS PROGRAMS

The Office of Small and Disadvantaged Business Utilization (OSDBU) was created by Public Law 95–507 and established in the Department of Veterans Affairs (VA) to assist and support the interests of small business.

A related mission of the office is to provide outreach and liaison support to businesses (large and small) and other members of the private sector concerning acquisition related issues. In addition, the office is responsible for monitoring VA's implementation and execution of the following socioeconomic procurement programs:

Small Business Programs:

Our small business program implements the requirements to aid, counsel, assist and protect the interest of small business concerns to ensure that a fair proportion of total purchases, contracts, and subcontracts for property and services for VA are placed with small businesses. For acquisition purposes, small businesses must be independently owned and operated, not dominant in the field of operation in which they are bidding on Government contracts, and otherwise qualify as small businesses under the criteria and size standards developed by the U.S. Small Business Administration (SBA).

(5) **Disadvantaged Business Program:**

For the purpose of improving and stimulating minority business enterprise, VA establishes a realistic Department-wide goal for the award of contracts to small business concerns owned and controlled by socially and economically disadvantaged individuals. OSDBU is also responsible for the Department's program to encourage greater economic opportunity for minority entrepreneurs. To implement these requirements, goals are established for each contracting activity for award of contracts to this socioeconomic program.

If your business is (a) at least 51 percent owned by one or more individuals who are both socially and economically disadvantaged and (b) managed and controlled by one or more such individuals, you are eligible to participate under this program.

Labor Surplus Area Program:

This program directs set-aside acquisitions in medical research, diagnosis and treatment, data processing, medical center construction, and other services to concerns that perform contracts in labor surplus areas. Labor surplus areas are those geographical areas identified by the Employee's Benefits, Employment and Training Administration of the Department of Labor, as areas of concentrated unemployment or under employment.

Women-Owned Business Program:

In response to the need to aid and stimulate women's business enterprise, this advocacy program directs acquisition officials to take appropriate action to facilitate, preserve, and strengthen women's business enterprise and to ensure full participation by women in the free enterprise system. Appropriate action includes the award of prime contracts and subcontracts and counseling of women-owned businesses. "Women-owned small businesses," means small business concerns that are at least 51 percent owned by women who are United States citizens and who also control and operate the business. OSDBU is responsible for negotiating with VA acquisition officials annual goals to increase Federal prime contracts and subcontracts with women-owned businesses.

Vietnam Era and Disabled Veteran-Owned and Operated Small Business (VOB) Program:

SBA has the legal responsibility to give "special consideration" to veterans of the Armed Services in all SBA programs. Consistent with that mandate and the mission of VA, we strongly encourage the participation of VOB's in the VA acquisition program. OSDBU is the advocate that monitors the Veteran-Owned and Operated Small Business Concerns program.

As part of each procurement action involving other than small purchase procedures, VA contracting activities are required to request, through the SBA Procurement Automated Source System (PASS), a listing of Vietnam era veteran-

W N Y VETERANS' HOUSING
COALITION, INC.

ANSWERS SUBMITTED BY
FRANK J. FALKOWSKI, CHIEF OPERATING OFFICER
WESTERN NEW YORK VETERANS' HOUSING COALITION INC.

TO

HONORABLE LANE EVANS, CHAIRMAN

SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS AFFAIRS

VETERANS HEALTH CARE, ECONOMIC OPPORTUNITIES AND SOCIAL SERVICES
FOR VETERANS & THEIR DEPENDENTS - A COMMUNITY PERSPECTIVE

1125 Main St., Suite 27 — Buffalo, New York 14209-2307
Phone (716) 885-8538 — Fax (716) 885-3073

QUESTION #1

The WNY Veterans Housing Coalition has been very successful. What lessons has the Coalition learned which can be used throughout the country?

ANSWER #1

The lessons learned by the Coalition that could be used throughout the country are as follows:

Lesson 1:

To operate a successful Nonprofit Development Company we have found the following components to be critical for success.

SOLID AND REALISTIC STRATEGIC PLANNING FOR EXTERNAL FUNDING: This would include:

* Identifying programs and projects that accomplish your exempt purpose. Even if an activity generates revenue that you use to finance tax-exempt project costs, that revenue might not be tax exempt and it may jeopardize your organizations' tax exempt status on certain projects. Nonprofit business leaders who conduct housing development must have access to timely information on financial, business management and tax issues.

* Analyze Resources. Nonprofit Property Development demands an appropriate staff (Development Team), administrative support system and financial resources to conduct the start up analyzation and feasibility factors relative to site control and community support for the projects that you want to pursue.

* Early identification of any deficiencies in development budgets and schematic design will prevent costly construction overruns and change orders which are not viewed favorably by funding sources and in most cases are never approved for funding after the application is received.

Lesson #2

ACCESS THE COMPETENCE OF YOUR ORGANIZATION

Funding sources have intensified their evaluation of applicants. Assessing the adequacy of your development staff and consultants is an important factor in competition.

Continuous self-evaluation must be done to help leverage your chances of obtaining future grants and contracts. When securing multiple sources of funding for one project, careful evaluation must be undertaken so that first and second positions in the financial package are clearly defined and do not overlap in the final development budget.

Lesson #3

Collaboration with other organizations is an excellent opportunity for an organization to develop the resources and experience it needs to compete with other organizations in obtaining and performing programs and contracts for property development and homeless veteran projects. This reduces potential liability issues and maximizes available resources while reducing the "cost of doing business". It has been our experience that a minimum of $20 - 30 thousand dollars in seed money is necessary to start a project. These monies fund the start up costs associated with a new project and include data relative to site control, grant consultants, test borings and environmental reports that all public funding sources as well as private sector lenders require up front in their financial development proposals.

Unlike private for-profit developers, many nonprofits are indigent financially and do not have the luxury of having unrestricted funds to cover these initial project costs as listed above. If they are successful in securing a construction grant then some of these expenses are reimbursed in the initial construction draw.

QUESTION # 2

HOW CAN THE SUCCESS OF THE COALITION BE DUPLICATED IN OTHER COMMUNITIES?

ANSWER #2

Our successes and that of other Veteran Organizations involved in housing development can be duplicated as follows:

* By establishing a National Advisory Network or Committee whose membership composition includes successful nonprofit developers who are in the fore front of providing housing and supportive shelter services to the veteran population. This committee or working group could provide critical information to organizations who need assistance in developing their own housing programs and/or services. Information from this group could prevent financial pit-falls that most of us have learned the hard way from trial and error. This committee or advisory panel could work with the Congressional Committee on Veterans Affairs, The National Homeless Veterans Coalition or the William Joiner Center.

* This National Advisory Committee could prepare and present successful development models and position papers related to their successful projects as well as networking a system of components that are critical to completing a successful and cost effective project. Information provided would include but not be restricted to:

Development Team Composition

Utilization of consultants and contract negotiations

Securing seed monies and leveraging private sector resources.

Start up costs relative to site control, site preparation, and cost controls during the schematic design process.

Development of generic policies and procedures that are standard safe guards used during construction phases.

Compliance with the American With Disabilities Act and the various "gray areas" that exist in the design and construction phases.

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